Documentation for risk adjustment
Quick reference guide

Priority Health®
The information presented here complies with accepted coding practices and guidelines as defined in the ICD-10-CM coding book. It is the responsibility of the health care provider to produce accurate and complete documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to properly support the use of the most appropriate ICD-10-CM codes according to the official coding guidelines.
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What is risk adjustment?

Risk adjustment is a methodology that is used to account for known health data elements to level-set comparisons of wellness among members. The risk adjustment process occurs annually and requires capturing each member’s full burden of illness.
Risk adjustment is important because it drives both Centers for Medicare and Medicaid Services (CMS) Medicare capitation payment and the Patient Protection and Affordable Care Act (PPACA) product premium retention. For Medicare, diagnoses map to Hierarchical Condition Categories (HCC) and are generally cumulative, resulting in higher capitation payments from CMS. For PPACA, diagnoses map to HCCs, but are not tied to predictable dollar amounts; rather they are used in a points system by which all plans in the state are evaluated at the end of every year. Priority Health is engaged in developing strategies that account for the unique timelines and fiscal impacts of each risk adjustment methodology.

Medicaid members are also risk adjusted and the health plan’s risk score is determined by a historical cohort of members. This, in turn, is then applied to a future population of enrollees within the same risk score levels. As with all risk adjustment models, data completeness and quality are the biggest implementation challenges. Provider education around clinical documentation is key.
Benefits of risk adjustment

Priority Health utilizes risk adjustment strategies to cover the cost of care and keep premiums low for our members, while ensuring we meet CMS expectations for risk-adjusted plans.
CMS has established aggressive goals and expectations for Medicare Advantage health plans to “improve patient care through the identification of certain risk factors, personalized health advice, and referral to additional preventative services and lifestyle interventions.”

*The single most critical factor for meeting CMS’ expectations is to have a complete and accurate annual assessment of each member’s health status as the basis for driving optimal care and treatment.*

At Priority Health, we’ve identified the following risk adjustment strategies to provide the care our members need at the right cost, while meeting these expectations:

- Result in a complete and accurate health record
- Identify and engage members who may not be properly managing their chronic conditions
- Guide population health strategies
- Share Priority Health savings to providers in the form of gain/risk-sharing arrangements
- Increase CPC+ reimbursement for participating providers
- Increase PIP incentive reimbursement for participating providers on specific measures
Documentation guidelines

The key to our successful relationship is dependent on our providers providing timely and accurate documentation so we may receive proper reimbursement for risk adjustment products. This, in turn, gives us the ability to provide improved benefits to our members.
The key to our successful relationship is dependent on our providers providing timely and accurate documentation so we may receive proper reimbursement for risk adjustment products. Members we serve who have chronic medical conditions require additional services beyond preventive care. Correctly documenting is crucial in order to obtain appropriate reimbursement to cover these additional services. This also gives us the ability to provide improved benefits to our members.

Problems assessed during the encounter need to have supportive documentation in the Progress Note. Progress Notes found in electronic medical records typically contain the following components (please note order may vary by institutions).

**Assessment** = Problems addressed during the encounter (decision making complexity, including concerns with outcomes, morbidity or mortality, can either be included in this section, or incorporated in other sections of the note)

**CC** = Chief Complaint - concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter

**HPI** = History of Present Illness - chronological description of the development of the patient’s present illness (may include one or all of the following depending on the complexity: location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms)
Brief and Extended HPI’s are distinguished by the amount of detail needed to accurately characterize the clinical problem or problems:

- **Brief** consists of 1 to 3 elements
- **Extended** consists of 4 or more elements

**PE** = Physical Exam

**PFSH** = Past, Family, and/or Social History

**Plan** = Orders (medications, diagnostics, patient education, DMEs, etc.)

**ROS** = Review of Systems - signs and/or symptoms the patient may be experiencing per body system

**REMEMBER, IF IT IS NOT DOCUMENTED – IT DIDN’T HAPPEN!**
The overarching goal for risk adjustment is to code all documented diagnoses to the highest level of specificity. Every diagnosis reported as an active, chronic condition must be documented with an assessment and plan of care, reflecting the MEAT or TAMPER concept. Properly utilizing MEAT ensures coders pick the correct evaluation and management level for each date of service (DOS).

**MEAT** is an acronym used to describe four factors that help providers to establish the presence of a diagnosis during an encounter in proper documentation.

- Managed or monitoring
- Evaluated
- Assessed
- Treated

Diagnoses can be reported from any portion of the medical record provided they are accurately documented as current. A simple list of diagnoses is not acceptable or valid per official CMS coding guidelines, nor does a simple list meet the definition of assessment and plan.

A current problem list is important so other providers can know the medical condition of the patient. It also serves as a reminder to address each chronic condition at least once a year.
The TAMPER approach involves reviewing the chart for admissible evidence and knitting it together to tell the comprehensive and accurate story for on-going and future care of a patient. Diagnoses and TAMPER can be found within the DOS.

**TAMPER** is an acronym that means:

- **T**reatment: Surgery, therapy, procedure, counseling, education, DME ordered/given, lab(s) ordered
- **A**ssessment: Acknowledging/giving status/level of condition
- **M**onitoring/Medicate: Ordering/referencing labs/other tests/prescribing medication
- **P**lan: Plan for management or follow-up of condition
- **E**valuate: Examining (as in physical exam)
- **R**eferral: Referral to specialists for treatment or consultation of a confirmed condition

*TAMPER does not rely on billing regulations, but comes from an HCC coding perspective that refers to the CMS guidance for valid risk adjustment coding.*
Purpose of practitioner signature
Priority Health requires the individual who ordered and/or provided services be clearly identified in the medical records.

Acceptable digitized/electronic signatures:

- The responsibility for and authorship of the digitized or electronic signature should be clearly defined in the record.

- A “digitized signature” is an electronic image of an individual’s handwritten signature. It is typically generated by encrypted software that allows for sole usage by the practitioner.

- An electronic or digitized signature requires a minimum of a date stamp (preferably includes both date and time notation) along with a printed statement such as, “Electronically signed by,” or “Verified/reviewed by,” followed by the practitioner’s name and preferably a professional designation. An example would be: Electronically signed by: John Doe, MD 3/01/2018.

Unacceptable signatures:

- Signature “stamps”

- Missing signature on dictated and/or transcribed documentation

- “Signed but not read” indicators

- Illegible lines or marks
Rules for reporting diagnosis codes
It’s important to code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Members receiving a prescription for over one year must also have a concurrent diagnosis to support the medication.

History codes (Z codes) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. (ICD-10-CM Guidelines IV) Priority Health will accept and encourage up to 12 diagnosis codes on our professional outpatient claims.

**Accurate diagnosis coding provides Priority Health with a snapshot of medical conditions affecting our member population and appropriately deploys case management resources. Chronic conditions need to be reassessed each year for risk adjustment purposes.**
Hierarchical Condition Categories (HCC)

There are over 250 HCCs, although not all are applicable to the Medicare product or the Individual Patient Protection and Affordable Care Act product. Some HCCs are applicable for both products.
Risk Adjustment and Hierarchical Condition Category (HCC) coding is a payment model mandated by the Centers for Medicare and Medicaid Services (CMS). This model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual’s health conditions and demographic details.

The risk adjustment models are accumulative, meaning that a patient can have more than one HCC category assigned to them. There is a hierarchy of categories and some categories override other categories.

For each member, the HCC must be captured each year and is important for the medical record to document all diagnoses from the patient encounter.

Specificity in documentation allows the most current and accurate ICD-10 codes to be assigned. This paints a more accurate picture of the patient’s current health status. Where applicable, the documentation should specify the orientation of the presenting illness (i.e. right arm, left hip), as over a third of ICD-10 codes contain laterality.

*Priority Health focuses on capturing the full burden of illness each year for our Medicare and PPACA members.*
Unspecified codes

Unspecified HCCs should be used in rare circumstances where a more specific code is not available. Most unspecified codes do not quantify an HCC, but there are some unspecified codes which do suffice as HCC appropriate. Here are examples of unspecified codes which do suffice as HCC appropriate:

B18.9 – chronic viral hepatitis, unspecified

F20.9 – schizophrenia, unspecified

F33.40 – major depressive disorder, recurrent, in remission, unspecified

G82.20 – paraplegia, unspecified

I20.9 – angina pectoris, unspecified

Reminder: Unspecified codes should be rarely used and in extenuating circumstances.
Certain health status codes are very important to assess, document and code at least annually using the highest level of specificity:

- Transplants
- Asymptomatic HIV
- Ventilators

“Status of” conditions:

- Tracheostomy status
- Dialysis
- Artificial openings/ Ostromies
- Prosthetics/ Amputations

Status conditions must reflect active conditions that require treatment or influence medical decision making. Be sure to document the issues at least once a year while the patient has the status. If a patient has an artificial opening closed, that date should be on the problem list.
Asthma

Common signs and symptoms of asthma include coughing, wheezing, chest tightness and shortness of breath. While asthma affects people of all ages, symptoms most often manifest during childhood. When documenting asthma, there are three criteria to follow to ensure accurate coding is captured:

- **Cause**
- **Severity (Mild, Moderate, Severe)**
- **Temporal Factors (Acute, Chronic, Intermittent, Persistent, Status Asthmaticus, Acute Exacerbation)**

General coding guidelines in ICD-10-CM instruct that codes describing symptoms and signs are acceptable for reporting when the provider has not established a related, definitive (confirmed) diagnosis. If applicable, physician documentation should include if the condition is due to use or exposure to tobacco.
Cancer—active

A cancer diagnosis indicates that the patient has active disease. Patients with active cancer may or may not be receiving treatment (treatment may include, but not limited to surgery, chemotherapy or radiation).

If adjuvant endocrine therapy or adjuvant chemotherapy is being administered, the cancer is considered active and should be coded accordingly; examples of adjuvant therapy includes Casodex, Tamoxifen, Lupron and 5-FU.

Patients in remission should have a diagnosis reflecting their condition (e.g. C91.91 Lymphoid leukemia, unspecified, in remission). Remission diagnoses are disease specific.

Once the treatment is complete and the cancer has been eradicated (the cancer is neither active nor in remission) and should be coded as “history of” from category Z85-.

Please refer to the ICD guidelines for specifics and questions regarding coding conditions.
Chronic obstructive pulmonary disease

COPD refers to chronic bronchitis, emphysema and alpha-1 antitrypsin deficiency, a genetic form of emphysema. COPD is characterized by the obstruction of airflow and interference with normal breathing. Chronic bronchitis and emphysema frequently coexist. Coding and sequencing for COPD are dependent on the physician documentation in the medical record and application of the official coding guidelines for care.

It is important to document the status of the member’s pulmonary disease annually. Documenting the stability or successful self-management of the disease, is just as important as documenting the exacerbations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J44</td>
<td>Other chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>J44.0</td>
<td>Chronic obstructive pulmonary disease with acute lower respiratory infection</td>
</tr>
<tr>
<td>J44.1</td>
<td>Chronic obstructive pulmonary disease with (acute) exacerbation</td>
</tr>
<tr>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified</td>
</tr>
</tbody>
</table>
Chronic DVTs, PE and coagulation defects

Patients with a history of chronic deep vein thrombosis, chronic pulmonary embolism or coagulation defects may be treated with anticoagulants which are managed in a “Coumadin Clinic”. It is important to document and assess the current status of these chronic conditions in the progress note from each visit.

Confirming that the correct diagnosis is available in the problem list may act as a helpful reminder. Additionally, documenting the date and diagnosis/findings of the last diagnostic test (e.g. duplex scan) within the problem list prevents providers from repeatedly searching for results.

Below are some examples of diagnoses. Please remember that this list is not all inclusive, and is only to be used for exemplary purposes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I27.82</td>
<td>Chronic pulmonary embolism</td>
</tr>
<tr>
<td>I82.501</td>
<td>Chronic embolism and thrombosis of unspecified deep veins of right lower extremity</td>
</tr>
<tr>
<td>I82.502</td>
<td>Chronic embolism and thrombosis of unspecified deep veins of left lower extremity</td>
</tr>
<tr>
<td>D68.9</td>
<td>Coagulation defect, unspecified</td>
</tr>
<tr>
<td>D68.59</td>
<td>Other primary thrombophilia</td>
</tr>
<tr>
<td>D68.69</td>
<td>Other thrombophilia</td>
</tr>
</tbody>
</table>

*Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient’s medical record.*
Diabetes mellitus

Diabetes mellitus (DM) is a condition that results when the body is unable to produce enough insulin or properly use the insulin that it does produce.

Assign as many codes in the table below as needed to identify all of the associated conditions that the patient has. When the provider assesses the condition, additional documentation is necessary to completely classify the condition: type 1 vs. type 2 and manifestations associated with the condition, if any.

There are five diabetes mellitus categories in ICD-10-CM:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08</td>
<td>Diabetes mellitus due to an underlying condition</td>
</tr>
<tr>
<td>E09</td>
<td>Drug or chemical-induced diabetes mellitus</td>
</tr>
<tr>
<td>E10</td>
<td>Type 1 diabetes mellitus</td>
</tr>
<tr>
<td>E11</td>
<td>Type 2 diabetes mellitus</td>
</tr>
<tr>
<td>E13</td>
<td>Other specified diabetes mellitus</td>
</tr>
</tbody>
</table>

An additional code should be assigned from category Z79- to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned.
Diabetes with chronic kidney disease

With ICD-10 there is a presumed linkage between diabetes and chronic kidney disease. However, the best practice is to document any cause-and-effect relationships for diabetes with chronic kidney disease and neuropathy.

You can establish a link between diabetes and kidney condition by documenting the following:

- Diabetes with chronic kidney disease, stage I
- Diabetic chronic kidney disease, stage III
- Chronic kidney disease, stage I due to diabetes
- Chronic kidney disease, stage II secondary to diabetes

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient’s medical record.

*Please refer to the ICD guidelines for specifics and questions regarding coding conditions.*
Diabetes with eye disease

Diabetic eye disease refers to a group of eye problems that people with diabetes may face as a complication of diabetes. All can cause severe vision loss or blindness. Documentation should be specific if there is a cause and effect relationship where the patient’s eye disease is due to diabetes.

Diabetic eye disease may include:

- **Retinopathy**: damage to the blood vessels in the retina.

- **Cataract**: clouding of the eye’s lens. Cataracts develop at an earlier age in people with diabetes.

- **Glaucoma**: increase in fluid pressure inside the eye that leads to optic nerve damage and loss of vision. A person with diabetes is nearly twice as likely to get glaucoma than other adults.

*Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient’s medical record.*
Peripheral vascular disease (PVD) includes several conditions that affect the blood vessels. PVD occurs when peripheral blood vessels, those located away from the heart, become blocked or damaged in some way. Peripheral artery disease, or PAD, is one type of PVD. It affects arteries in the arms and legs.

Links can be made between diabetes and peripheral vascular disease by documenting the following:

✓ Diabetes with peripheral vascular disease
✓ Diabetic peripheral vascular disease
✓ Gangrene caused by diabetes
✓ Peripheral vascular disease secondary to diabetes

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient’s medical record.
Diabetes with neuropathy

Document the cause and effect relationship if your patient’s neuropathy is secondary to diabetes to capture and code as a diabetic condition.

Neurological conditions may affect a patient’s memory and ability to perform daily activities. It is important to document treatment of these conditions once a year.

You can establish a link between diabetes and neuropathy by documenting the following:

- Diabetes with neuropathy
- Diabetic polyneuropathy
- Neuropathy caused by diabetes
- Polyneuropathy associated with diabetes
For example, when documentation supports a link between uncontrolled diabetes type 2 and neuropathy on insulin the code assignment would be:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.40</td>
<td>Type 2 diabetes mellitus with diabetic neuropathy, unspecified</td>
</tr>
<tr>
<td>Z79.4</td>
<td>Long-term (current) use of insulin</td>
</tr>
</tbody>
</table>

By documenting the cause and effect relationship, you can capture and code a more complete picture of your patient’s overall health.

*Please refer to the ICD guidelines for specifics and questions regarding coding conditions.*
Kidney disease—chronic

By definition, chronic kidney disease (CKD) is kidney damage for three months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done.

**CKD is classified into one of the five stages:**

<table>
<thead>
<tr>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD, Stage I</td>
</tr>
<tr>
<td>CKD, Stage II (mild)</td>
</tr>
<tr>
<td>CKD, Stage III (moderate)</td>
</tr>
<tr>
<td>CKD, Stage IV (severe)</td>
</tr>
<tr>
<td>CKD, Stage V</td>
</tr>
<tr>
<td>ESRD, Renal dialysis status*</td>
</tr>
</tbody>
</table>

*End Stage Renal Disease treated with dialysis would be coded with N18.6 for the ESRD and Z99.2 for the dialysis status.*

**The diagnosis of CKD cannot be coded from diagnostic reports (e.g., lab reports) alone. The diagnosis of CKD requires at least two abnormal markers of damage or two abnormal GFRs persisting more than three months.**
Protein-calorie malnutrition and cachexia are important diagnoses that are often overlooked in Medicare patients who have other significant chronic underlying diseases. Physicians often describe patients as frail or with significant weight loss but then do not document a clear diagnosis of malnutrition in the progress note.

**Symptoms include:**

<table>
<thead>
<tr>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary weight loss &gt;10% in the previous few months</td>
</tr>
<tr>
<td>BMI &lt;18.5</td>
</tr>
<tr>
<td>Poor nutrition or loss of appetite or seriously curtailed food intake</td>
</tr>
<tr>
<td>Daily GI symptoms such as anorexia, nausea, vomiting or diarrhea for at least two weeks</td>
</tr>
<tr>
<td>Marked reduction in physical capacity</td>
</tr>
<tr>
<td>Wasting appearance or muscle wasting</td>
</tr>
</tbody>
</table>

*Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient’s medical record.*
Mental health disorders

Mood disorders that produce depression may exhibit as sadness, low self-esteem or guilt feelings; other manifestations may be withdrawal from friends and family, or interrupted sleep. We encourage providers to address mental health concerns because unmanaged mental health issues can exacerbate a patient’s other health conditions. We encourage our providers to screen for depression on a routine basis – at least annually. Use of the PHQ-2, PHQ-4 and PHQ-9 tools will help assess depressive symptoms and risk for suicide. These tools and other resources can be found on the Priority Health provider center.

Major depressive, bipolar and paranoid disorders require very specific documentation. It is important to clearly indicate severity of condition such as mild, moderate, severe, with or without mentions of psychotic symptoms, recurrent or single episode, or in full or partial remission.

Priority Health behavioral health staff are available 24/7 for emergencies and assistance.

Call 616.464.8500 or 800.673.8043. Our business hours are Monday through Thursday, 8 a.m. to 5:30 p.m., and Friday, 8 a.m. to 5 p.m.
Myocardial infarction (heart attack)

Myocardial infarction (MI) is the death of myocardial tissue usually caused by a blocked coronary artery. Acute MI (AMI) is classified to ICD-10-CM subcategories I21.0-I21.4 and I22.0-I22.9.

Types of Myocardial Infarctions include ST Elevation Myocardial Infarction (STEMI) or Non ST Elevation Myocardial Infarction (NSTEMI).

Acute Myocardial Infarction (AMI) ICD-10-CM code is I21 and is used for only a four week period. Following the initial four week period, ICD-10-CM code I25.2 can be used. A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction is to be used when a patient who has suffered an AMI has a new AMI within the four week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

Selection of an ICD-10-CM diagnosis code is based on the documentation in the medical record. Refer to the ICD guidelines for specifics and questions regarding coding conditions.
Obesity increases risk of diabetes, heart disease, stroke and arthritis, as well as other diseases and conditions.

The diagnosis of being overweight or obese must be documented and coded from the provider’s chart notes because the Body Mass Index (BMI) code alone does not capture the abnormal weight condition. Therefore, unless the physician makes a comment on the significance of the BMI, it cannot be coded.

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (Z68.1)</td>
<td>&lt;18.5</td>
</tr>
<tr>
<td>Normal weight (Z68.2-)</td>
<td>18.5 - 24.9</td>
</tr>
<tr>
<td>Overweight (E66.3)</td>
<td>25 - 29.9</td>
</tr>
<tr>
<td>Obesity (E66.9)</td>
<td>30 or greater*</td>
</tr>
<tr>
<td>Morbid obesity (E66.2)</td>
<td>40 or greater*</td>
</tr>
<tr>
<td>Super morbid obesity (Z68.43)</td>
<td>50+</td>
</tr>
</tbody>
</table>
Providers are encouraged to bill BMI or BMI percentile ICD-10 diagnosis code on any PCP E&M claim regardless of the patient’s BMI value.

*From a clinical perspective, a BMI of 35+ linked to a supported comorbidity of obesity by the clinician (comorbidities may include diabetes, hypertension, sleep apnea, COPD, cardiovascular disease: history of MI, CHF, venous stasis, atherosclerosis, osteoarthritis - weight bearing joints, and CVA) may be coded as morbid obesity ICD-10 E66.01. If there is no BMI documented and the member’s appearance is listed as ‘massively overweight’ morbid obesity may also be coded.
Post-cerebrovascular accident

Acute cerebrovascular accident (CVA) is coded I63 and should only be used in a hospital setting.

ICD-10-CM diagnosis code I63 is used for the initial episode for an acute cerebrovascular accident. Because a cerebrovascular accident is an acute event, it should not be documented as an active diagnosis for prolonged periods of time.

ICD-10-CM code for “History of” or current CVA is not to be used. Following hospital discharge, use Z86.73 if there is no lasting sequelae or “Old CVA with late effects” (i.e. aphasia, slurred speech, gait problem, etc.).

- Categories I60 – I67 are used to indicate the area of the cerebrovascular disease.
• Category I69 is used to indicate sequelae of CVA, including conditions specified as such or as residuals which may occur at any time after the onset of the causal condition.

• Late effects may be present from the onset or may arise any time after the acute phase.

• There is no time limit on coding late effects of a CVA.

• Weakness vs. hemiparesis. Please be specific with documentation.
Vascular disease

Vascular disease includes any condition that affects the circulatory system.

Vascular disease ranges from diseases of the arteries, veins and lymph vessels to blood disorders that affect circulation. The following are conditions that fall under the category of vascular disease:

- Peripheral artery disease
- Aneurysm
- Renal (kidney) artery disease
- Reynaud’s phenomenon
- Varicose veins
- Blood clots
- Lymphadema
- Atherosclerosis of aorta

*Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient’s medical record.*
When to query the provider

A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Providers should be queried whenever there is conflicting, ambiguous or incomplete information in the health record regarding any significant reportable condition or procedure.
Queries are deemed appropriate when documentation in the patient’s record fail to meet the following criteria:

**Clarity** — Diagnosis listed without statement of cause or suspected cause. Procedures not clearly documented to the suggestive documentation implied by CPT lay descriptions

**Completeness** — Entries to the patient record that do not correlate with clinical indicators or diagnostic tests

**Consistency** — Information documented that is conflicting, or not substantiated

**Correctness** — Instances when clinical reports suggest a need for more specific documentation

**Legibility** — Illegible handwritten notes where the data cannot be assessed for coding

Queries should not be used to question a provider’s clinical judgment, and may only be used to clarify documentation when it fails to meet criteria.

The following use of information is encouraged to assist coding staff for a query process:

- ICD-10-CM Guidelines for Coding and Reporting
- American Hospital Association Coding Clinic
- CPT Assistant
- CMS Correct Coding Initiative (CCI)
Acronyms and industry terms
**BMI** — Body Mass Index

**CHF** — Congestive Heart Failure

**CKD** — Chronic Kidney Disease

**CMS** — Centers for Medicare and Medicaid Services

**COPD** — Chronic Obstructive Pulmonary Disease

**CPC+** — Comprehensive Primary Care Plus

**CVA** — Cerebrovascular accident (stroke)

**DOS** — Date of Service

**DM** — Diabetes Mellitus

**DVT** — Deep Vein Thrombosis

**ESRD** — End Stage Renal Disease

**HCC** — Hierarchical Condition Categories

**MI** — Myocardial Infarction

**NSTEMI** — Non-ST Elevation Myocardial Infarction

**PE** — Pulmonary Embolism

**PIP** — Partners in Performance

**PPACA** — Patient Protection and Accountable Care Act

**PVD** — Comprehensive Primary Care Plus

**STEMI** — ST Elevation Myocardial Infarction
Care management
Priority Health supports members with complex and/or serious health issues with an in-house team of more than 70 advance-practice nurses, doctors, pharmacists and certified case managers.

Our case managers help coordinate health care for Priority Health members who:

• Are at risk for a high-cost, episodic, acute event
• Have a condition that could lead to an increased use of services
• Have suffered a catastrophic health episode

Referrals to care management services may be made by calling the care management triage line at 800.998.1037.
Priority Health

contact information

Call the Provider Helpline
800.942.4765
Monday - Thursday 7:30 a.m. - 5 p.m. and
Friday 9 a.m. - 5 p.m.

Send us an e-mail:
provider.services@priorityhealth.com

Contact us by mail:
1231 E. Beltline NE
Grand Rapids, MI  49525-4501