



2019 Best Practices and Guidelines For Risk Adjustment and ICD-10-CM Coding

Coding Advisory Committee

Version 1.3

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I. Purpose

The Best Practices and Guidelines for Risk Adjustment and ICD-10-CM Coding document was created to highlight key medical record issues, as well as ICD-10-CM diagnosis coding guidance, to meet or exceed CMS HCC diagnosis code capture requirements to support appropriate reimbursement. There are many instances where CMS does not give clear guidance. In addressing various issues, Cigna-Healthspring (C-HS) outlines more rigorous guidance than what is required by CMS to reflect C-HS' commitment to best practices. The majority of the guidance contained in the document pertains to medical records created in the outpatient encounter setting, with a small focus on inpatient encounter medical records.

This document describes practices and guidelines that support the following methods of reducing RADV risk. RADV risk reduction is addressed in three primary ways:

1. Attempting to ensure coding guidelines are accurately followed
2. Attempting to ensure only documents valid for risk adjustment are used for coding
3. Attempting to ensure C-HS has a way to quantify the certainty that codes submitted to CMS are supported by medical record documentation

II. Ownership

The Best Practices and Guidelines for Risk Adjustment and ICD-10-CM Coding document was created by the Coding Advisory Committee. The document represents a revision to the original document published earlier to address guidelines relevant to medical records that were coded in the ICD-9-CM environment prior to 10/1/15. This version represents the guidelines pertinent to code capture for medical records in the ICD-10-CM environment effective **2/1/19**. All C-HS employees and contractors are expected to comply with the standards reflected in this document. Relevant employees and contractors will be given access to this document.

The Coding Advisory Committee comprises of Cigna-HealthSpring varied coding representation. This entity provides the foundation for the establishment of acceptable CMS RADV guidance for HCC diagnosis coding, as well as ICD-10-CM coding guidelines that are applied to all Cigna-HealthSpring coding initiatives. In keeping with the committee mission of balancing ICD-10-CM diagnosis code assignment with CMS Risk Adjustment Data Validation guidelines, the members of the Coding Advisory Committee will perform in the following capacities:

- Represent from the following areas: RADV audit response team, Operating Effectiveness/Internal Monitoring, Prospective/Retrospective coding initiatives, and RADV/Coding Subject Matter Experts. A varied coding representation team will provide the necessary skill set to support the attached guidelines with the least exposure to risk.
- Maintain ownership of the Cigna-HealthSpring Best Practices and Guidelines for Risk Adjustment and ICD-10-CM Coding document. The Committee will oversee the maintenance of the document by obtaining any applicable executive level approvals for coding philosophy changes, as well as regular updates and revisions warranted by on-going ICD-10-CM coding and/or CMS RADV guideline revisions. Clarity regarding internal coding inconsistencies will also be provided to the fullest extent possible.
- Hold monthly coding meetings to include coding leads from the following areas: market coding, provider education, ACC/Living Well, Prospective/Retrospective, and MDQO coding support.
- Oversee final ICD-10-CM coding guidance and determination that include appropriate interpretation, as well as setting Cigna-HealthSpring coding policy. Following a defined chain of communication will provide a mechanism for coding question escalation to the Coding Best Practice Committee for review and final determination.

Note: All new additions/deletions/revisions in this version are identified by red font

III. Abbreviations/Definitions

- **360:** The Cigna-HealthSpring health risk assessment. A comprehensive face-to-face encounter assessing the overall quality of health and wellness, status of chronic conditions, and diagnosis of new conditions. It is also a means for capturing pertinent HEDIS and Stars information.
- **ApplicationXtender (AppX):** Application and database where retrieved records are housed that were obtained from physician offices and outpatient/inpatient facilities.
- **Best Practice (BP):** Coding document created to highlight key medical record requirements, as well as ICD-10-CM diagnosis coding guidance, to meet or exceed CMS HCC diagnosis code capture for reimbursement.
- **BPHP:** Bravo Personal Health Profile, the 360 equivalent in the legacy Bravo markets (HS- EAST Annual Wellness Exam through 2012).
- **C-HS:** Cigna-HealthSpring
- **Coding Event:** A group of multiple patients' charts coded within a given timeframe, or during a single engagement at a provider's office.
- **Chart:** All documents for one patient, for all dates of service, found at a location. A "location" may be at a PCP or Specialist office, within an EMR, or at a hospital.
- **CMCR:** Comprehensive Medical Chart Review – the act of reviewing a patient's chart, abstracting the diagnoses documented in the chart, and recording additional codes in a database. CMCR helps to ensure completeness of codes; other mechanisms are used to help ensure the accuracy of codes selected.¹
- **CMS:** Centers for Medicare and Medicaid Services
- **DOB:** Date of birth
- **DOS:** Date of service
- **EMR/EHR:** Electronic forms of medical records
- **Enhanced Encounter (EE):** an alternate format of the Cigna-HealthSpring health risk assessment. A comprehensive face-to-face encounter completed using the Lumeris ADSP (Accountable Delivery System Platform). Similar to the 360, the "EE" assesses the overall quality of health and wellness, status of chronic conditions, and diagnosis of new conditions. It is also a means for capturing pertinent HEDIS and Stars information.
- **HCC:** Hierarchical Condition Category. Grouping of diagnosis codes used by CMS to determine reimbursement level for a patient.
- **HMR:** A Health Management Report document completed and returned by the provider.

➤ ¹ Consistent with CMS guidance, Cigna-HealthSpring understands that it is not possible to achieve perfect accuracy or completeness in data submitted to CMS. Data accuracy and completeness necessarily should be viewed in the aggregate and relative to the fee-for-service Medicare program. Cigna-HealthSpring has communicated its understanding to CMS. CMS, for its part, has indicated that it is not possible to determine whether an overpayment exists for Risk Adjustment Validation Audit ("RAD-V") purposes until CMS issues a final rule for a fee-for-service adjuster, and any litigation that may be brought to challenge the final rule is resolved. Cigna-HealthSpring is awaiting CMS's promulgation of a final fee-for-service adjuster rule to further inform the organization's ability to assess the accuracy of its Risk Adjustment Data. Cigna-HealthSpring is aware that the U.S. District Court for the District of Columbia has held that CMS should ensure actuarial equivalence by, for example, issuing a fee-for-service adjuster. Cigna-HealthSpring is also aware that CMS has recently proposed to reverse its policy and not to implement a fee-for-service adjuster. By definition, the fact that the rule is only proposed means that CMS has not altered its policy requiring a fee-for-service adjuster.

- **HRA:** Health Risk Assessment
- **IRR:** Inter-Rater Reliability Review. A blind secondary review of a record where the results from the secondary review are compared to the original review and differences are scored.
- **MDQO:** Medicare Data Quality Operations. Enterprise group that operationally supports market coding teams, conducts CMS data submissions, provides reporting and data analytics in the area of risk adjustment, and seeks to ensure CMS guidelines are met in the area of risk adjustment.
- **MI:** Myocardial Infarction
- **New Coder:** A person who has been with the coding department <= 6 months.
- **OSCR:** One Source Coding Repository – application and database that holds diagnosis codes recorded during CMCRs, review of 360s, and other coding programs.
- **Participant Guide:** The 2008 CMS Risk Adjustment Technical Assistance for Medicare Advantage Organizations Participant Guide, a source for guidance around RADV and associated requirements.
- **RADV:** Risk Adjustment Data Validation. An audit performed by CMS where medical record documentation is submitted in support of HCCs for which we have received reimbursement.
- **Unique Identifier:** Pieces of unique information that are specific only to the patient. Some examples are member ID #, HICN, SSN, and DOB.

Please Note: This document does not provide a solution to every coding scenario. It is within the coder's judgment and responsibility to escalate questions and/or unusual documentation to the appropriate coding manager for further clarification and coding guidance.

IV. Documentation Requirements

A. Diagnosis Code Abstraction

1. The guidance below will assist in identifying when it is acceptable to abstract a diagnosis from a provider record.
2. It is the coder's role to fully confirm, to the best of his or her ability, that all ICD-10-CM code assignments he/she has entered into the OSCR application, for each encounter, are accurate, correct, and abide by ICD-10-CM coding guidance. These guidelines address the coder's role in attempting to verify the appropriateness for code assignments; they do not extend to internal compliance processes for the acceptance/denial of Cigna-HealthSpring prospective assessment completion (see page 28 for Prospective Review compliance).
3. Note new ICD-10-CM guidelines effective 10/1/16: Section I, A, 19. "Code Assignment and Clinical Criteria: The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."

NOTE: For the purpose of C-HS coding initiatives this statement excludes the scenario when an acute condition is documented on a physician/outpatient setting for follow-up (i.e. acute CVA's, acute MI's).

Guideline	Retrospective (CMCR)	Prospective (EE, 360, HMR)
1. All clearly documented diagnoses, per coding guidelines, that are evaluated, assessed, and treated with additional supplemental status codes that are pertinent to the patient's care (personal history, surgical history, medication, etc.) should be captured. (Note: exceptions for chronic conditions on pg. 6 and for prospective assessments on pg. 28)	✓	✓
2. The coder will review and abstract codes based on the documentation encounter.	✓	✓
3. If a single condition is re-assessed by the provider on multiple dates of service, the coder should still code the condition every time it is documented with treatment.	✓	✓
4. Documentation of the status (stable, improving, etc.) of the condition or care instructions (given) does not replace the need for a specific treatment plan.	✓	✓
5. Current treatment plans should be documented at the diagnosis point of entry within the Assessment and Plan section. Treatment plans may include: monitoring, medications, orders for labs/testing, and referrals.		✓
6. Current treatment plans documented in the assessment, or in other areas such as the History of Present Illness, are also acceptable practice. Treatment plans may include: monitoring, medication(s), order for labs/testing, and referrals.	✓	
7. Acceptable forms of treatment that are documented under EMR header language of 'Problem Story' are acceptable <u>unless</u> there is knowledge/evidence that the documentation is pre-populated and was not specifically generated at the face-to-face encounter.	✓	✓
8. Treatment plan of "continue current treatment" is acceptable and equates with "monitor"; language must be associated to each diagnosis.	✓	✓

Coding Scope: The guidance of the following categories is as follows: (See FAQ under Pertinent Hx & Status Codes)

Category	Code not required	Code when pertinent
Family history conditions	✓	
Absence of organs		✓
Past Surgical History		✓
Past Medical History		✓
Exam/Screening	✓	

B. Chronic Conditions/ Problem Lists/ Past Medical History

NOTE: The guidance below does not apply to prospective coding initiatives for which all treatment plans must be documented at the diagnosis point of entry. Refer to page 30 for specific guidance on prospective coding initiatives.

An exception to the guideline for the presence of treatment plans for every diagnosis applies to these specific chronic conditions listed in the table below.

1. Certain conditions are considered chronic and impact the patient’s overall care, even when not the reason for visit on that date of service. CMS addresses *8 specific conditions considered “Co-Existing and Related Conditions” in the 2008 MA Participant Guide (*refer to the box below, and see additional conditions that meet the definition of chronic, that once present never resolve and impact the patient’s overall care).

When documented during the face-to-face encounter, these conditions are considered ongoing and often managed by medication. While we believe that CMS will accept them as listed in a RADV audit, our best practice is to ensure there is demonstration of current review in the form of medication, referrals, **order of** lab tests, etc. Additional chronic conditions listed below defined as once present never resolve, also follow this rule.

Alzheimer’s Disease	*Chronic Obstructive Pulmonary Disease	HIV/AIDS	*Rheumatoid Arthritis (RA)
*Atrial Fibrillation	*Diabetes	*Multiple Sclerosis (MS)	
Chronic Diabetic Manifestations	*Heart Failure (if not stated as acute)	Osteoporosis	
Chronic Kidney Disease	*Hemiplegia	*Parkinson’s Disease	

2. Lists titled as active/chronic conditions, problem lists, and past medical history vary between paper records and electronic records. It is important to pay special attention to the way these are documented. These lists only apply to certain chronic conditions that meet the above rule and demonstrate treatment.
3. Diagnoses that reflect a personal history of certain pertinent conditions that can continue to impact the patient’s care, or overall health and well-being, should be code captured:

Old MI or history of MI	Amputation Status	Transplant Status	Dialysis Status
Ostomies/Artificial Openings (when confirmed present by physical exam findings or by ostomy supply orders, etc.)		Certain other post-surgical statuses such as CABG, PTCA, Pacemaker, AICD, etc. History of PE, DVT, CVA, infectious diseases, or any other condition that is being followed for future risk to the patient’s health	

4. The use of “history of” in diagnostic statements can be confusing and misleading. Many providers will use the statement to indicate that the patient has had the conditions historically, and continues to have them. This makes it difficult to determine the best methods for code abstraction. Based upon this guidance, any documentation where the provider has used the term(s) “history of” will be coded using the appropriate diagnosis code for the historical condition based upon the alphabetic and tabular indexes. Provider education should be provided accordingly when determined that the condition referenced as a “history of” is a chronic condition currently undergoing treatment.

a. Note: Some exceptions include chronic conditions for which the provider also documented treatment in the same statement. Example below:

- History of Diabetes, continue daily insulin

C. Patient Identifiers

(Refer to page 30 for further instructions on prospective reviews)

Patient identifiers include:

- Patient's full name (required)
 - Date of birth (DOB) (required *see exception under 1.a.)
 - Other unique identifier specific to the patient (i.e. medical record number, patient's age)
1. To pass administrative compliance, the document must have a **minimum of 2** patient identifiers: the patient's full name and date of birth.
 - a. **First page:** generally requires the patient's full name and date of birth, except when
 - the patient's full name and 1 additional unique identifier are present (when the DOB/age is **not** present)
 - b. **Subsequent pages:** generally require the patient's full name, the date of birth, **OR** 1 other patient identifier, except when:
 - The patient's name and any other patient identifiers are absent beyond the first page, then the document must be numbered showing a cohesive record.
 - Fax page numbers are present in lieu of EMR page numbers, this is acceptable.
 - EMRs without any pagination corroborate the encounter date with the dates captured in the vital signs and signature, this is acceptable.
 - The patient's name and any other patient identifiers are absent beyond the first page, but are "pagination batch" scenarios applying to the entire medical record, and beyond the individual encounters, this is acceptable.
 - c. Handwritten medical record documentation that references the patient's age is acceptable as a secondary patient identifier.
 - ✓ Example: Jane Smith Age 73
 2. Should missing patient identifiers be a trend with a particular provider, escalate the issue to your coding market lead.

Examples	
Page 1	OSCR error flag needed?
Patient name/ with DOB/ with DOS	no
Patient name /with 1 other unique identifier /with DOS	no
Patient name / without additional identifier /with DOS	yes
Single page without any patient identifiers	yes
Patient name/ without DOS	yes

Examples	
Subsequent pages	OSCR error flag needed?
Patient name/ with DOB/ with DOS	no
Without patient name and/or DOS with clear page numbering progression specific to encounter	no
Without patient name and/or DOS with clear unique other page numbering progression specific to encounter (i.e. report number, MRN)	no
Without patient name/ with date other than DOS (i.e. "print date- 1/1/18") with page numbering progression specific to encounter	no
Without patient name/ without DOS/ with clear page numbering progression not specific to encounter (batch numbering sequence)	no
Patient name/ with DOB/ without DOS and without pagination (excludes exceptions above)	yes
Without patient name / without clear progression from page to page, such as date of service or page numbers (excludes exceptions above)	yes

D. Date of Service

1. A clear date of service is required in order to abstract the diagnoses for the date of the face-to-face encounter. It is best that the date of service be present on each page. If not present on subsequent pages, **the document must meet one of the following requirements:**
 - It is ideal that the subsequent pages be numbered. This shows document cohesion pertinent to the date of service. Please review the exceptions below:
 - In absence of page numbering, the encounter date must be confirmed with the vital signs recorded date and the provider signature date.
 - “Pagination batch” scenarios that apply to the entire medical record, and beyond the individual encounters, are acceptable.
 - Fax page numbering can be used in the absence of EMR pagination.
2. In cases of consultation letters, the date of service should be mentioned within the note. For example, “I had the pleasure of seeing Mrs. Smith in my office on 1/5/2012,” or, if the consultation letter is dated, “I saw Mr. Jones in my office today.” Should the date of service not be clearly stated in the case of a consultation, **enter the diagnoses with the date of the letter.**
3. Should the document lack a date of service entirely (does not meet bullets 1 or 2), do not abstract the codes and make a note of that record.

E. Acceptable/Unacceptable Document Sources

1. **Acceptable Document Sources:** Documents that show evaluation of the patient and clinical findings, assessment, and treatment. For example:

History and Physical	Progress Note	Consultation
Full Inpatient Medical Record	Discharge Summary	Operative reports and Procedure notes w/ post-operative diagnoses

2. **Unacceptable Document Sources:** Documents that *do not* show evaluation of the patient and clinical findings, assessment, and treatment. For example:

Super bill	Physician-signed attestation	Referral Forms	A list of patient reported conditions
A diagnostic report that has not been interpreted by the treating provider	Telephone notes	Physician Orders	EMR Chart Abstraction document (summary)
DME and Home Health	Alternative data sources (medication list, registries, etc.)	Documents from unacceptable provider types (nutritionist, radiologist, etc.)	Prescriptions
“Unofficial Copy” stamped medical records			

F. Provider Specialties

1. Determine from the documentation that an evaluation of the patient was face-to-face, and performed by a physician or an acceptable physician extender (e.g., physician assistant, nurse practitioner).
2. Ensure the provider is an acceptable Provider Type. (See CMS Physician Specialty List Attachment on page 31).

Examples of <u>Acceptable</u> Credentials: (list is not exhaustive)			
Specialty	Specialty Credential(s)	Specialty	Specialty Credential(s)
Doctor of Medicine, Medical Doctor	MD	Doctor of Osteopathic Medicine	DO
Audiologist	Au.D., MA CCC-A	Occupational Therapist	OT
Certified Clinical Nurse Specialist	CNS	Optometry (specifically means optometrist)	OD
Certified Nurse Midwife	CNM	Oral Surgery	DDS, DMD
Certified Registered Nurse Anesthetist	CRNA	Physician Assistant (no oversight signature required)	PA
Chiropractic	DC	Physical Medicine and Rehabilitation	DPM
Licensed Clinical Social Worker	LCSW	Physical Therapist	PT
Nurse Practitioner (no oversight signature required)	NP, ARNP, DNP, FNP, ANP, CRNP, APN, APRN, CNS, APR-CNS, Psych CNS	Podiatry	DPM
Resident	MD, DO	Psychologist	PhD, PsyD

Examples of <u>Unacceptable</u> Provider types include: (list is not exhaustive)			
Specialty	Specialty Credential(s)	Specialty	Specialty Credential(s)
Medical Assistant	MA	Certified Medical Assistant	CMA
Registered Medical Assistant	RMA	Registered Nurse	RN
Licensed Practicing Nurse	LPN	Medical Student without MD credential	MSI-IV
Physician Assistant Student	PA-S	Nurse Practitioner Student	NP-S
Licensed Professional Counselor	LPC	Doctor of Pharmacy	PharmD

G. Provider Identifiers and Signatures

1. Provider identifiers include the three required components of the full printed name, credential, and signature. **The provider's full printed name is not required elsewhere if the provider can be clearly identified by a completed legible signature with credential. (Applicable only to handwritten signatures)**
(See Unacceptable/Acceptable Signature attachment on page 31)
2. Ensure all three components of a valid signature exist:
 - physician signature
 - physician credentials
 - date entries

Signature Requirements	Electronic Medical Records (EMR)	Handwritten Notes	Dictated Notes	360 and HMR	Enhanced Encounter (EE)
Signature	Required	Required	Required	Required	Required
Credentials	Must be present on practice stationery letterhead if not present within the electronic signature statement	Must be present on practice stationery letterhead if not present with signature	Must be present on practice stationery letterhead if not present with signature	Must be present on practice stationery letterhead if not present with signature	Follow EMR requirements
Date Entries	Need to be present within electronic statement	Can be inferred by date of service if not present with signature	Can be inferred by date of service if not present with signature	Must be present with signature (Refer to links on pg. 28 for further guidance.)	Follow EMR requirements
Signature Verbiage	Needs to be present within electronic statement. See #3 below.				Follow EMR requirements

3. Ensure Electronic Medical Records indicate appropriate signature verbiage and a date stamp (time stamp is not required). If the signature consists only of the typed provider's name with no other indication of signature status, then it is not a valid signature.

Acceptable EMR phrases (list is not exhaustive)			
Electronically Signed By	Authenticated By	Signed by	Validated by
Acknowledged by	Approved by	Closed by	Confirmed by
Digitally signed by	Entered by	Finalized by	Generated by
Performed by	Reviewed by	Verified by	Accepted by
Charted by	Completed by	Created by	Entered data sealed by
Read by	Released by	Sealed by	Written by

Unacceptable EMR signatures (list is not exhaustive)			
Signed to expedite, but not proofread	Auto-Authorized	Electronic signature on file without a date and time	Electronically signed to expedite delivery
Administratively signed by	Dictated, but not signed	Electronically signed, but not authenticated/verified	Signed but not read/reviewed

G. Provider Identifiers and Signatures (cont'd)

4. Typically, electronic signatures appear at the conclusion of the medical record documentation. However, an electronic signature that appears at the beginning of the documentation is also acceptable with acceptable signature requirements.
5. Ensure signatures are executed within a timely manner. The timeframe for preferred signature is within 72 hours, but acceptable up to **180** days,
6. Under Cigna-HealthSpring's internal standards, addendums cannot exceed 90 days from the encounter date without approval of the Compliance Officer, with the exception of clarifications, corrections, and on a case-by-case basis.
7. Signature Stamps are not acceptable.
8. The title "Dr. " cannot replace the provider credentials. The credentials must be present within the signature or letterhead stationery.
9. A provider that is called a "Resident" is an acceptable physician provider that has the credentials of MD/DO and does not require the attestation of the oversight physician provider.
10. Dictated Notes: A note stating, "Dictated, but not read or signed" is unacceptable. (Presence of a handwritten signature does override the dictated status of "Dictated but not read or signed")
11. For CMCR reviews only, if no records are signed in an office, do not capture codes and escalate the issue to your market lead
12. Credentials and Co-signatures
 - a. A provider's signature and credentials attest to the care that was delivered. The signature itself, of the treating provider, validates that the medical record documentation accurately reflects the treating provider's intentions, plan of care, medical decision making, and services performed during the encounter.
 - b. The presence of a compliant oversight physician signature, along with their face-to-face presence and attestation to the care delivered (see 12.a.), overrides a non-compliant signature from the resident physician.

For CMCR reviews only, if a signature is invalid, or questionable for any of the above reasons, capture the diagnosis codes and flag the review with the appropriate error code in OSCR. **It is crucial to flag these codes as having signature issues for downstream reporting and assessment for submission to CMS.*

H. Medical Scribes

Resource: Page 37 of the CMS "Medicare Program Integrity Manual" Chapter 3:

NOTE: Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries, (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's /non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. Reviewers are only required to look for the signature (and date) of the treating physician/non-physician practitioner on the note. Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.

I. Abstracting Inpatient documents found in provider record

General guidance applicable to coding stand-alone documents from inpatient facility records using **outpatient** coding guidelines.

1. Stand-Alone Discharge Summary

- a. Stand-alone discharge summaries that are part of the physician outpatient medical record will be entered using the discharge date as the date of service.
- b. When the discharge date is not present, do not code the discharge summary.
- c. Diagnoses stated as “resolved” that occurred during the inpatient encounter are acceptable to capture to the acute/active code. For example:
 - Acute CVA(Stroke): Admitted and treated for stroke
 - Colon Cancer: Admitted for colectomy
 - Gangrene: Amputation completed during admission
- d. Diagnoses that are resolved from previous admissions are acceptable to capture using a historical/status code when applicable. Use caution to distinguish what is resolved from previous encounters vs. the current encounter for the admission. (*Err on the side of caution if unclear documentation is present.*) For example:
 - Above knee amputation: If procedure occurred during prior admission, status code can be captured.
 - Colostomy: If procedure occurred during prior admission, status code can be captured if still present.
 - Mastectomy for Breast Cancer: If procedure occurred during prior admission, mastectomy status can be captured.
- e. A treatment plan must be present for diagnoses that are abstracted from the discharge summary. This includes medication, referrals, etc.

2. Inpatient History and Physical

- a. Admit date must be present.
- b. If actual date of service is not present, admit date can be used as date of service.

3. Inpatient Consultations

- a. Consult date must be present.
- b. Admit date cannot be used as date of service.

4. Inpatient Progress Notes & Inpatient Physical/Occupational Therapy Notes

- a. DO NOT code if found in the provider record.

5. Operative Report

- a. Only code when post-operative diagnoses are present.
- b. Procedure date must be present.
- c. Assign a code to the condition for the purpose of the surgical procedure and not the status condition. (e.g., knee replacement with post-op diagnosis of DJD knee.)

V. Internal Guidance for Code Abstraction

A. Abstracting from other SOAP components

Provider documentation can vary significantly. For that reason, we must read and evaluate the documentation in its entirety to ensure that the diagnosis abstraction is as accurate and thorough as possible. **NOTE: The guidance below does not apply to prospective coding initiatives. Refer to page 30 for specific guidance on prospective coding initiatives.**

Subjective – consists of the CC, HPI, ROS, Past, Family, Social, and Surgical History.

The HPI can appear in a narrative form where the provider discusses the chief complaint and the patient's current, or past, medical conditions. There are many examples where providers documented the status and treatment for patient conditions in this section. Conditions documented here, with clear evaluative language, may be abstracted as long as the condition is not patient reported.

Objective – consists of the Physical Exam.

Providers may document the objective physical findings from the face-to-face encounter in this section, but not include those details in the A/P. For example, the provider may document the location, dimensions, and status of an ulcer in the physical exam, without also addressing it in the A/P portion of the note. These types of conditions may be abstracted with caution. Coders can refer to the physical exam to gain specificity for conditions as long as active treatment is present. Status conditions such as ostomies may be confirmed within the physical exam.

Assessment/Plan – consists of the final diagnoses (Assessment) and the provider's plan for patient treatment and/or follow-up.

The Assessment/Plan section of the note is the most common location for diagnosis code abstraction.

B. Up and Down Arrows

1. Providers often use up and down arrows as a documentation short cut; however, AHA Coding Clinic has provided some guidance that explains these are not acceptable forms of documentation.
2. Up and down arrows have variable interpretations and do not necessarily mean abnormal; therefore, abstraction of a diagnosis identified with an up and down arrow is not acceptable. Refer to AHA Coding Clinic Q1 2014.

C. Code in Lieu of a Diagnosis

1. It is the provider's responsibility to provide clear documentation of a diagnosis; therefore, it is not appropriate to abstract a diagnosis from a listed code number. Diagnosis code abstraction should occur only by referring to the diagnostic statement documented by the provider. Refer to AHA Coding Clinic Q4, 2015.

D. “With” or “In”

ICD-10-CM coding guidelines Section I, 15. “With” or “In” definition

1. ICD-10-CM code updates effective 10/1/16 dates of service. Revised definition to support alphabetic index and presumed causal relationships
 - a. The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
 - b. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List.
 - c. 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.
 - d. 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 word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.
2. ICD-10-CM code updates effective 10/1/17 dates of service. Revised definition to support alphabetic index and presumed causal relationships with the term “**in**”. (Changes to guidelines are present in bold):
 - a. “The word “with” or “**in**” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
 - b. 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, **or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).**
 - c. For conditions not specifically linked by these relational terms in the classification, **or when a guideline requires that a linkage between two conditions be explicitly documented**, provider documentation must link the conditions in order to code them as related.”

E. Amputations

1. The ICD-10-CM codes Z89.01-Z89.9 are status codes used to report patients that are documented as having had a limb amputation. In the alphabetic index, under the main term Amputation, there is a subentry for “status (without complication). -See “Absence, by site, acquired”
2. The other subentry of “traumatic” is used to report patients that are being seen on that date of service for an amputation that occurred as a result of a traumatic injury (See Injury codes in Chapter 19). The traumatic codes are only used on the initial encounters related to treating the amputation.

For documentation within outpatient settings (360, HMR, Progress notes, CMCR) assign from code range Z89.01-Z89.9.

F. Application of 7th digit character in Chapter 19

- According to the ICD-10-CM guidelines, most categories in Chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter, with the exception of fractures which have additional characters, have three 7th character values:
 - “A” – Initial Encounter
 - “D” – Subsequent Encounter
 - “S” – Sequela
- The External cause code must have the same 7th digit.

“A” – Initial Encounter

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.			
Character “A” initial encounter is used while patient is receiving active treatment for the condition. Examples of initial encounters include:			
Initial Encounter (Emergency Room or physician’s office of clinic)	Surgical Treatment	Evaluation and continuing treatment by the same or different provider	Refers to the patient’s initial encounter with the INJURY and not with the physician
Does not include a new physician due to move out of state or retiring	Transfer to Long Term care facility for continuation of care such as antibiotic therapy, ventilator dependence, wound care	Malunions/nonunions of fractures when patient delayed seeking treatment	Referral to orthopedist for injury for post-operative infection
Wound vacuum treatment			

- Note: While the patient may be seen by a new or different provider over the course of treatment for the injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.**

“D” – Subsequent Encounters

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.			
Character “D” subsequent encounter is used for encounters after the patient has received active treatment of the condition, and is receiving routine care during the healing or recovery phase. Examples of subsequent encounters include:			
Cast change or removal	Removal of external or internal fixation device and suture	Other aftercare	Rehabilitation therapy
X-ray to check healing status of fracture	Medication adjustment	Follow-up visits following treatment (same or different provider)	PT, OT, pain management
Long term care for rehabilitation such as for joint replacement		Dressing changes	

F. Application of 7th digit character in Chapter 19 (cont'd)

“S” - Sequela

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.		
Character “S” sequela is used for complications or conditions that arise as a direct result of a condition. Examples of sequela include:		
Scar resulting from a burn	Quadriplegia due to spinal cord injuries	Chronic respiratory failure following drug overdose
Traumatic arthritis following gunshot wound	Skin contractures due to previous burns	

1. Need to use both the injury code and sequela code
2. “S” added to injury code, not the sequela code
3. “S” identifies the injury responsible for the sequela
4. No time limit
5. If chronic pain is documented as due to a previous injury, code G89.21 (chronic pain due to trauma) and injury code with 7th digit “S”
6. Do not use for an acute complication, such as wound infection
7. Do not use for complication of surgical treatment

Guidance for this section was obtained from the ICD-10-CM Coding Guidelines and AHA Coding Clinic article, Q1 2015, Applying the 7th Character for Injury, Poisoning and Certain Other Consequences of External Causes.

G. Uncertain Diagnoses (Outpatient Setting)

The Official ICD-10-CM Coding Guidelines, Section IV. H. states: “Do not code diagnoses documented as ‘probable,’ ‘suspected,’ ‘questionable,’ ‘ruled out,’ ‘working diagnoses,’ or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.”

Please note: This differs from the coding practices used by short-term, acute care, long-term, and psychiatric hospitals.

Key terms indicating uncertainty			
Appears to be	Probable	Ruled out	Suspected
Likely	Questionable	Suggestive of	Working diagnoses
Contributory to	Complicated by	Consistent with	Compatible with
Indicative of	Concern for	With characteristics of	

EXCEPTION: “evidence of” is not considered an uncertain diagnosis, and is acceptable for code abstraction in the outpatient setting. Refer to AHA Coding Clinic Q3, 2009.

H. Artificial Openings

The ICD-10-CM codes Z93.0-Z93.9 are status codes used to report patients that are documented as having a current artificial opening. This is often found in the documentation of the physical exam and/or in the surgical history. It is important to be sure that the documentation does not state that the artificial opening has been reversed. It is also important to be sure that any complications that are documented as being related to the artificial opening are coded correctly by searching for the main term “Complication” in the alphabetic index. Additionally, it is important to be able to differentiate between an artificial opening and other devices. For example, a Foley catheter is not an artificial opening, but a device placed into an existing opening (natural opening).

Common terms to look for when coding artificial openings:

- The suffix –ostomy (colostomy, tracheostomy, urostomy, gastrostomy, ileostomy, vesicostomy, nephrostomy)
- Suprapubic catheter
- Stoma

I. Tobacco Use/ Dependence

It is important to pay close attention to the language of the documentation when abstracting codes from nicotine dependence for ICD-10-CM. When abstracting codes for active nicotine dependence, documentation must show treatment for the condition.

1. Per AHA Coding Clinic Fourth Quarter 2013, “Smoker” is coded to dependence. Assign code F17.200. Nicotine Dependence, unspecified, uncomplicated, when the provider documents “smoker”. *Please note the following reference in the Alphabetic Index to Disease: Smoker-see Dependence, drug nicotine.*
2. “Smoking” does not imply dependence. A code does not exist for this terminology.
3. When coding history of tobacco dependence (Z87.891), documentation must be supported with language of dependence such as stating history of “smoker” or history of tobacco dependence.
4. Per AHA Coding Clinic Fourth Quarter 2013, Provider must document a cause-and-effect relationship between smoking and COPD; it cannot be assumed to assign F17.218. Code F17.210 Nicotine, dependence, cigarettes, uncomplicated, would be assigned along with J44.9 when no further documentation is present.

Key terms to assist in identifying abuse/use or dependence		
Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.		
Description	Use	Dependence
Smoker		✓
Smoking (no code available)		
Tobacco abuse	✓	
Tobacco use	✓	
PMH: Smoker		✓
History of nicotine/tobacco dependence		✓
History of smoking (no code available)		
History of tobacco use (no code available)		
Examples of treatment include: smoking cessation, counseling, etc.		
Although packs per day (PPD) and total years of smoking shows that the condition was assessed, a treatment plan is required to code capture the condition.		

J. Abbreviations and Abbreviated Words

Providers will often use abbreviations in their diagnostic statements and throughout the record. Care must be taken when abstracting these for coding. Only acceptable abbreviations should be used in clinical documentation. Providers whose documentation contains inappropriate or incorrect abbreviations should receive education as to the acceptable abbreviations for those certain conditions. Any diagnoses would not be abstracted.

Abbreviations that appear to have multiple meanings should be used in the context of the documentation. Should there be any inference, or uncertainty, do not abstract the diagnosis.

Care should be taken when abstracting diagnoses when there are multiple definitions for the abbreviation. Example “MD” can be Manic Depression or Macular Degeneration. The coder should only code an abbreviated condition when there is evidence of supportive treatment.

Acceptable abbreviation resources:

- Medilexicon.com
- Stedman’s

Acceptable ophthalmology abbreviation resources:

<http://www.aao.org/young-ophthalmologists/yo-info/article/learning-lingo-ophthalmic-abbreviations>

http://optometry.nova.edu/ce/tpacc/forms/common_optometry_abbreviations.pdf

K. Malignant Neoplasms

Cancer, or malignant neoplasm, is a diagnosis that has specific guidelines outlined for the appropriate code selection of a current versus an historical cancer. If a patient has had an active cancer code submitted, but the particular record indicates that the patient actually has a history of the cancer, treated outside of that data collection year, the active cancer code (and associated HCC) will not be validated.

1. Official ICD-10-CM Coding Guidelines, Chapter 2.d. states “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.”
2. It is important to note that the documentation of a patient being on prophylactic treatment, such as Tamoxifen for female breast cancer, is not considered active cancer treatment and should be reported by assigning the Z code for the Tamoxifen use, along with the Z code for the personal history of the cancer.
3. “History of” vs. Active Cancer: When explicit documentation of ongoing current anti-neoplastic treatment is not present, and provider documentation is inconsistent to the active status of the malignancy, the history of cancer code should be assigned.

L. CVA/TIA, Acute Myocardial Infarction, and Sepsis in the Outpatient Setting

1. Diagnoses of Strokes, acute MI's, and Sepsis would not typically be assigned in the outpatient setting. The coder should carefully examine the physician/outpatient setting documentation before assigning these codes.
 - a. Cerebrovascular accidents, or strokes, occur when blood flow to a specific part of the brain stops. This can be caused by ischemia or hemorrhage. When the blood flow is cut off for too long, cell death occurs and can result in sequela (late or long term effects), or brain death. The documentation is the key to assigning the appropriate diagnosis code. Codes I63.00-I63.9 are used to report the acute phase of the CVA during the episode of care when the actual CVA is occurring. Subsequent episodes of care would be coded to the history of CVA (Z86.73) or to the late effects (I69.3xx) based upon documentation. The code I67.89 should not be used to report any stroke related conditions that are current or historic.
 - b. A TIA is a transient version of the CVA where symptoms resolve quickly and no residual deficits or evidence remains. They are also known as impending strokes. This is coded to G45.9 for the initial episode of care during the acute phase of the condition. Subsequent episodes of care would be coded using Z86.73. It is important to educate providers on the proper documentation of the late effects of the CVA, as a causal relationship is required in order to use codes from the I69.3xx category.
2. Myocardial Infarction (MI) is the death of myocardial tissue usually caused by a blocked coronary artery. Caution should be exercised when documentation states "history of MI," particularly if it does not specify when the initial MI occurred. Official ICD-10-CM Coding Guidelines, Chapter 9.e instructs that codes from category I21 will continue to be reported for encounters occurring while the MI is equal to, or less than, 4 weeks old, and the patient requires continued care; this includes transfers to another acute setting or post-acute setting. If after the 4 week time frame the patient is still receiving care related to the MI, then the appropriate aftercare code should be assigned rather than a code from category I21. Old or healed myocardial infarctions not requiring further care are assigned to I25.2
3. Sepsis is a life-threatening condition that develops when the chemicals the immune system releases into the bloodstream to fight an infection cause inflammation throughout the body instead. Sepsis/Severe Sepsis is based on causative organisms. Please refer to the Official ICD-10-CM Coding Guidelines for specific instructions on coding Sepsis, based on the causative organism. Urosepsis is a non-specific term. According to the Official ICD-10-CM Coding Guidelines, it is not to be considered synonymous with sepsis. Coders should carefully review the aforementioned coding guidelines as well as clinical documentation to assign the right codes for sepsis, severe sepsis and septic shock. If the underlying infection or causative organism is not further specified for an accurate diagnosis of Sepsis, code A41.9, Sepsis, unspecified organism, should be assigned.

M. Weakness secondary to late effect of CVA

1. Following AHA Coding Clinic First Quarter, 2015, "When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. "

Please note: Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless associated with other brain disorders or injury. This excludes unilateral weakness stated as with an upper or lower extremity, which should be coded to monoplegia.

N. Long-term (current use) of Insulin

1. Z79.4 is used for reporting a patient's continuous use of insulin.
Note: Long-term (current use) of other families of medications are not required for code capture.

0. Depression

Careful distinction of documentation must be made when coding various forms of Depression. The provider must clearly outline the type and episode of Depression within the diagnosis.

1. Anxiety Depression: conditions must be clearly linked together to capture a combination code
 - Anxiety Depression: assign combination code
 - Anxiety with Depression (or vice versa): assign combination code (“with” establishes the relationship - see section on “with”)
 - Anxiety and Depression (or vice versa): does not establish a relationship. When a clear relationship is not documented, Anxiety and Depression must be coded separately
2. Mild Depression: careful review of the diagnosis and episode is key to correct code capture. Mild Depression and Major Mild Depression represent two different and unique types of Depression that are further defined by the episode as initial or recurrent
 - Mild Depression NOS: defaults to Depression NOS
 - Mild Depression, recurrent episode: defaults to Major Depression, mild, recurrent episode
 - Mild Depression, single episode: defaults to Depression NOS
3. Major Depression: can be further defined as mild, moderate, and severe. Note key word in diagnosis must first be defined as **Major or recurrent** in order to assign code specification as mild, moderate, and severe.
4. Episodes: defined as initial or recurrent per provider documentation. Coder cannot assume episode of care.
5. Medications: coder cannot correlate medications for Depression or further specification to a “Major” Depression without clear provider documentation
6. Partial/Full remission: requires clear provider documentation

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.				
Diagnostic Statement	Anxiety	Anxiety Depression Combo	Depression /Major Depression NOS	Major Depression category (code to severity, episode, or remission if specified)
Anxiety and Depression (or vice-versa)	✓		✓	
Anxiety Depression		✓		
Anxiety with Depression (or vice-versa)		✓		
Mild Depression /Mild Depressive disorder			✓	
Depressive disorder, single episode			✓	
Major Depression/Depressive disorder, single episode			✓	
Major Mild Depression/Major Mild Depressive disorder			✓	
Mild Depression, recurrent episode				✓
Depression/Depressive disorder, recurrent episode				✓
Major Mild Depression/Major Mild Depressive disorder, recurrent episode				✓
				✓

P. Diabetes Mellitus

1. Diabetes and manifestations

- a. **Presumed causal relationships:** Per ICD-10-CM updates effective with 10/1/16 dates of service, a new guideline applies that “presumes” causal relationships:

A major change to the Conventions section of the ICD-10-CM guidelines under “with” (see excerpt on “with”) now supports recent 1st and 2nd quarter 2016 coding clinics on guidance for coding diabetes with manifestations. This new guidance, along with the alphabetic index structure change, allows a manifestation listed under Diabetes “with,” to be **automatically presumed related, unless the provider specifically documents another cause other than Diabetes.**

- b. Instances where the provider specifically documents another cause for the manifestation will result in code assignments for the separate conditions rather than the diabetic complication code.

- i. Exception to the rule applies for coding **Senile (age-related) Cataracts and Diabetes.**

Per coding clinic guidance, provider documentation of Diabetes Mellitus and Senile (age-related) Cataracts should be linked together. See AHA Coding Clinic 2016, 4th qtr. titled “*Diabetic Cataract.*” Only the combination code for Diabetes Mellitus with Diabetic Cataract should be assigned. A separate code for senile (age-related) cataract should not be assigned in accordance with ICD-10-CM combination code assignment guidance.

- c. Conditions that do not meet the presumption guideline, and are not found indented under “with” or “**in**” in the DM alphabetic index, will require provider documentation to identify a causal relationship. Key linkage terms must be present. A causal relationship would not include conditions that co-exist or complicate DM, but must establish a relationship of DM as the cause for a particular condition.
- d. The coder **cannot presume that a condition** meets the presumption rule by the DM complication NEC terms such as: DM with [circulatory / neurologic / renal / ophthalmic / skin] complications. For this instance, the provider would need to specifically link the manifestation to the DM. Ex. Diabetes with Hypertension (per [AHA coding clinic 2017, 4th quarter.](#))

Acceptable linkage term/symbols:

- ✓ ‘with’ or ‘w/’ or \bar{c} (‘with’ symbol -lowercase c with line over it)
- ✓ ‘due to’
- ✓ ‘secondary to’ or 2°
- ✓ ‘diabetic’
- ✓ ‘in’ (effective 10/1/2017)

Unacceptable linkage terms/symbols:

- ☒ Complicated by
- ☒ Slashes (/)
- ☒ Comma (,)
- ☒ ‘and’
- ☒ \bar{s} (‘without’ symbol - lowercase s with line over it)

P. Diabetes Mellitus (cont'd)

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.	
Assessment Diagnosis	Is a causal relationship present with DM?
1. Hypertensive Retinopathy 2. Diabetes	No, provider specifically documents another cause for retinopathy.
1. Diabetes 2. Hypertensive CKD	Yes, per coding guidelines, CKD can be linked to both Diabetes and Hypertension, unless the provider states otherwise.
1. Skin ulcer 2. CKD 3. DM	Yes, per coding guidelines manifestations may be linked to diabetes.
1. Diabetes Type II 2. Neuropathy	Yes, per coding guidelines manifestations may be linked to diabetes.

2. **Uncontrolled diabetes:** Per AHA Coding Clinic Article First Quarter 2017, there is no default code for “uncontrolled diabetes,” and the provider must document whether hyperglycemic or hypoglycemic. If documentation does not identify the type, query the provider for clarification. If unable to query the provider, uncontrolled diabetes should be coded to Diabetes Mellitus, uncomplicated by type.
3. **Diabetes Type 1 vs. Type 2**
 - a. Provider documentation determines DM type for code assignment. Age is not the sole determining factor.
 - b. Type 2 DM is the default code in the absence of the DM type. This also applies when the medication list includes insulin.
4. **Diabetes and use of insulin and oral hypoglycemic drugs**
 - a. Code Z79.4 is assigned when documented with DM type 2, or unspecified type, when insulin is prescribed for long term (current) use. Z79.4 should not be assigned when only prescribed on a temporary basis to bring blood sugar levels under control
 - b. **NEW** – code Z79.84 is assigned for long term (current) use of oral hypoglycemic drugs
 - c. When both oral hypoglycemic and insulin medications are prescribed, only the code for long-term (current) use of insulin should be assigned.
5. **Diabetic Retinopathy**
 - a. Diabetic Retinopathy that has been treated with laser photocoagulation therapy can be effective but is not curative, even when documented as “inactive.” Code capture the Diabetes Mellitus with ophthalmic retinopathy for these instances.

Q. Hypertension

ICD-10-CM updates effective with 10/1/18 dates of service, outlines a revised guideline:

“The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term ‘with’ in the alphabetic index. 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.”

1. Hypertension with Heart Disease

Hypertension with heart conditions classified to I50. - or I51.4-**I51.7, I51.89**, I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use an additional code(s) from category I50, Heart failure, to identify the type(s) of heart failure in those patients with heart failure. The same heart conditions (I50.-, I51.4-**I51.7, I51.89**, I51.9) with hypertension are coded separately **if the provider has documented they are unrelated to the hypertension. Sequence according to the circumstances of the admission/encounter.**

2. Hypertension with Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. **CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.** The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease

3. Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when **there is hypertension with both heart and kidney involvement.** If heart failure is present, assign an additional code from category I50 to identify the type of heart failure. The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

R. Incidental findings on radiological studies

1. An abnormal incidental radiological finding that has no clinical significance, nor current signs and symptoms for the patient, should not be coded as a condition.
 - a. Example: Granuloma and old granulomatous disease
2. When the documentation is unclear in meeting this definition, the coder must query the provider first.
3. Resources:
 - a. AHA coding clinic 2010 3rd quarter- Incidental Findings on Radiology reports for Outpatient Encounters

“It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a patient being seen ... “[in the emergency department (ED). The ED physician would need to clarify that the finding was clinically significant and related to the visit in order for it to be coded.”]

S. Cardiology

1. **Coronary Artery Disease**

Coronary artery disease is also known as ASHD (arteriosclerotic heart disease). When coding this condition there are several specific code assignments based upon the documentation of whether or not the disease is affecting the native arteries, bypass grafts, or the coronary artery of a transplanted heart.

a. **Terms for Coronary Artery Disease: (Category I25)**

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.			
CAD	Atherosclerotic Cardiovascular Disease	Coronary artery atheroma	Coronary artery atherosclerosis
Coronary artery sclerosis	Coronary Artery Disease	ASHD- Arteriosclerotic Heart Disease	

b. **Coronary Artery Disease with Angina**

- In accordance with ICD-CM guidelines, Chapter 9 Section B, a causal relationship can be assumed if both Coronary artery disease and angina pectoris are both present unless documented as related to other disease. Only the combination code would be utilized.

c. **Coronary arteries bypass graft**

- Unless the type of artery is specified, code to the native artery.

d. **Status Post codes**

- Coronary artery bypass grafts utilize status codes.
 - CABG
 - Coronary bypass
 - Saphenous vein graft (SVG)
- Coronary angioplasty
 - PTCA - Percutaneous Coronary Angioplasty
 - POBA - Plain Old Balloon Angioplasty
 - Cardiac stents
 - Drug eluding stent - DES
- Vascular Stents and grafts
 - Peripheral vascular angioplasty status with and without implants and graft

2. **Myocardial Infarctions**

- Acute Myocardial Infarctions per ICD-10-CM includes note states a duration of 4 weeks.
- Types:
 - STEMI - ST elevation
 - NSTEMI - Non -ST elevation
 - Other types: 1, 2, 3, 4a, 4b, 4c, and 5 (per FY2018 ICD10CM updates; see AHA coding clinic 2017 Q4-Myocardial types)

Terms for old myocardial infarction:

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.			
Old MI	Old AMI (acute Myocardial Infarction)	STEMI (in PMH)	MI (in PMH)
Heart attack (in PMH)	Old myocardial infarction	Previous MI	Previous Cardiac infarction
Coronary Artery Thrombus resulting in an MI (in PMH)	Healed myocardial Infarction	Type 1, 2, 3, 4a, 4b, 4c, or 5 MI	

S. Cardiology (cont'd)

3. Heart Failure

- Review documentation for the following: **Acute, Chronic, Acute on chronic, or Unspecified.**
- **Types of Heart Failure: NEW LIST**

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.		
Diastolic	Systolic	Combined Systolic and Diastolic
Left Ventricular	Congestive	Right (Ventricular)
Biventricular	High Output	End Stage (Stage D)

a. Terms associated with Heart Failure: REFORMATTED

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.		
Cardiac	Myocardial, Myocardium	Preserved ejection fraction
Decompensated	Low Output	Reduce ejection fraction
Compensated	Normal ejection fraction	

- b. Refer to AHA coding clinic article 2017 First Quarter regarding congestive heart failure with diastolic or systolic dysfunction. If the provider has linked either diastolic or systolic dysfunction with acute or chronic heart failure, it should be coded as "acute/chronic diastolic or systolic heart failure." If there is no linkage with the heart failure and dysfunction, assign code I50.9, heart failure unspecified.

4. Valve Disease

- Per ICD-10 coding index, default code is rheumatic unless stated as non-rheumatic (whenever the mitral and/or tricuspid valves are affected).
- Verify both include and exclude notes, patient cannot have both rheumatic and non-rheumatic.
- Non-rheumatic code sets do not contain a multiple code, and are coded separately when valves are involved.

5. Arrhythmias and Cardiac devices

The underlying dysrhythmia should not be coded in addition to the status code for the device, unless the provider's documentation clearly states that the underlying condition is symptomatic, and requires attention above and beyond what is expected for regular follow-up or device management. Refer to AHA Coding Clinic Article 2010 3rd quarter or 1993 5th issue.

a. Types of Cardiac Devices:

Please note that this is a non-exhaustive list of examples. The coder must evaluate and review the documentation to assign the most appropriate code.		
Pacemaker (cardiac)	Biventricular	ICD – Implantable cardioverter-defibrillator
Cardiac Defibrillator	AICD – Automatic Implantable Cardiac Defibrillator	

T. BMI and Nutritional Diagnoses

1. BMI scores in the normal range should always be coded with the appropriate Z code.
2. Provider documented nutritional status diagnoses of Malnutrition, Overweight, Obesity and Morbid Obesity can be code captured in the absence of a BMI score when the condition is supported with a treatment plan.
3. Code assignment for abnormal BMI scores can only be assigned and supported by the following:
 - a. Applies to BMI scores that fall outside of the normal BMI range
 - i. **Abnormal range for Ages 18-64: (BMI \leq 18.5 and BMI \geq 25)**
 - ii. **Abnormal range for Ages 65 and older: (BMI \leq 18.5 and BMI \geq 30)**
 - b. **Must include a nutritional status diagnosis that addresses a form of malnutrition, overweight, obesity, or morbid obesity that is documented by an acceptable provider.**
 - c. The BMI score itself can also be obtained and coded from dietician or nurse documentation once the requirement has been met for a documented diagnosis by the provider.
 - d. It is unacceptable to pull a diagnosis of obesity, morbid obesity, etc. from the physical examination.
 - e. Currently ICD-10-CM does not align codes that are defined with the National Institutes of Health (NIH) Obesity Classes 1, 2, 3. Provider documentation must contain terms that are found in the ICD-10-CM alphabetic index.
 - f. The nutritional status diagnosis can be code captured from the Assessment/Treatment Plan section, or, additionally for retrospective coding initiatives, from the History of Present Illness (HPI) section of the medical record when a treatment plan is documented.
 - g. **When there is an inconsistency between the patient's nutritional status diagnosis and the BMI score, neither should be code captured with an ICD-10-CM code.**
 - i. In cases where a provider has made a diagnosis of morbid obesity with a BMI score between 35 and 39.9, the provider must have documented a corresponding condition as defined by the National Institutes of Health (NIH) definition of morbid obesity. Thus one of the following conditions must be addressed as active:
 - Coronary artery disease
 - Peripheral vascular disease
 - Abdominal aortic aneurysm
 - Carotid artery disease
 - Diabetes mellitus, type 2
 - Sleep apnea
 - Hypertension
 - Hyperlipidemia
 - h. **A provider documented nutritional status of *Malnutrition*, equates with a BMI at any value, depending upon the specific spectrum of each patient.**
4. **For instances when only the BMI score is documented without a nutritional status diagnosis, the BMI score itself, (Z code), should not be coded.** However, for quality purposes, the BMI raw score itself should be captured in the HEDIS module of the OSCR application.
5. **Since BMIs have specific industry standards, it is not acceptable to round up a BMI to obtain another nutritional diagnosis. (i.e. BMI 29.93 with documentation of obesity).**

T. BMI and Nutritional Diagnoses (cont'd)

6. Coding Resources:

a. NIH BMI Classifications:

Table 1

Classifications for BMI	
	BMI
Underweight	<18.5 kg/m ²
Normal weight	18.5–24.9 kg/m ²
Overweight	25–29.9 kg/m ²
Obesity (Class 1)	30–34.9 kg/m ²
Obesity (Class 2)	35–39.9 kg/m ²
Extreme obesity (Class 3)	≥40 kg/m ²

b. ICD-10-CM coding guidelines Section I, B. 14. Documentation for BMI...

“The Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification. The BMI, coma scale, and NIHSS codes should only be reported as secondary diagnoses.”

c. ICD-10-CM Coding guidelines, Section I, Chapter 21 c. Z68 Body Mass Index.

BMI codes should only be assigned when the associated diagnosis (such as overweight or obesity) meets the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). Do not assign BMI codes during pregnancy.

d. AHA coding clinic 2008, 4th qtr.

“...If the BMI has clinical significance for the patient encounter, the specific BMI value may be picked up from the dietitian’s documentation. The provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. To meet the criteria for a reportable secondary diagnosis, the BMI would need to have some bearing or relevance in terms of patient care...”

e. Electronic Clinical Quality Improvement/CMS:

Ranges listed below are only applicable to high abnormal BMI’s ≥23. Abnormal low BMI’s will continue to be assessed at <18.5 regardless of patient’s age.

Normal Parameters:

Age 65 years and older BMI => 23 and < 30 kg/m²
 Age 18 - 64 years BMI => 18.5 and < 25 kg/m²

VI. Inpatient Coding Guidelines

Please Note: The inpatient coding guidelines should only be referred to when a full inpatient record is being reviewed as one encounter. Outpatient coding guidelines should be used if stand-alone documents such as discharge summaries, inpatient consults, etc., are found within a provider record and coded separately as single encounters.

General guidance applicable to coding inpatient facility records using **inpatient** coding guidelines.

1. Confirm the admission and discharge dates are evident in the record. These should typically appear on the Discharge Summary.
2. Confirm that the encounter was ordered as an “admission.” Encounters that are ordered as an “observation” should be coded using **outpatient** coding guidelines with the admission date as the from/thru date (even if the discharge occurred 1-2 days later). Observation encounters are not classified as true admissions and must be coded as an outpatient encounter.
3. In order for the record to be supported as an inpatient record, confirm that a minimum set of inpatient documents are present (admission record, discharge summary, history & physical, physician orders/physician progress notes/consultation reports, procedure reports [if applicable]).
4. Confirm the Discharge Summary is compliantly signed (see Signature guidance pages 7-8).
5. Code capture all current conditions listed on the discharge summary that meet inpatient coding guidelines and received treatment.
6. Uncertain diagnosis. If the diagnosis at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” or other similar terms indicating uncertainty, code the condition as if it existed or were established. The basis for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term, and psychiatric facilities. (Per ICD-10-CM guidelines Section II. H.)

- a. Ruled-out conditions upon discharge should not be coded
7. When applicable, code any chronic conditions that received treatment and met requirements (see chronic condition guidance on page 10).
 8. When applicable, further specificity of a condition that is listed as a final diagnosis may be obtained from procedure or pathology reports. Ex. Femur fracture that is further specified to site and laterality on an x-ray)
 9. Do not code from other inpatient documents other than the final discharge summary. While additional conditions may be documented on other acceptable inpatient source documents, the coder should only code capture those final diagnoses documented on the discharge summary to reduce risk of questionable corroboration by the attending physician.
 10. Do not code from the coding DRG assignment document, or the admission record, as they are not acceptable source documents.
 11. A Discharge Summary report is not required for lengths of stay less than 48 hours. In lieu of a discharge summary, a final discharge progress note is acceptable when a list of final discharge diagnoses, final disposition and follow-up is documented by the attending physician.

***** Any team member abstracting diagnosis codes utilizing inpatient coding guidelines *must* be a certified inpatient coder.**

VII. Prospective Exam Best Practices

1. For prospective coding initiative guidance only.

- a. The 360/Enhanced Encounter (EE) Comprehensive Assessment is the Cigna-HealthSpring annual Health Risk Assessment (HRA).
- b. To be compliant with CMS guidance on the coding and documentation of the HRA (as cited in their resource below, c.) all current/chronic conditions evaluated during the 360/EE Comprehensive Assessment must be addressed in the current conditions/assessment section of the medical record. A treatment plan must be documented for every active condition at the diagnosis point of entry by the acceptable examining provider (refer to page 5 for acceptable forms of treatment plans).
- c. Diagnoses that reflect a personal history of certain pertinent conditions that can continue to impact the patient’s care, or overall health and well-being, should be code captured.

Old MI or history of MI	Amputation Status	Transplant Status	Dialysis Status
Ostomies/Artificial Openings (when confirmed present by physical exam findings or by ostomy supply orders, etc.)		Certain other post-surgical statuses such as CABG, PTCA, Pacemaker, AICD, etc. History of PE, DVT, CVA, infectious diseases, or any other condition that is being followed for future risk to the patient’s health	

- d. CMS Resources
 - i. **Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance As of 9/27/2017, page 35:**

“Health Risk Assessment (HRA) forms must be completed by a valid risk adjustment provider specialty. Those completed by the patient are not acceptable. The documentation must support that the provider was present with the patient. Problem lists documented on the HRA are understood to not be under the care of the provider conducting the assessment. Conditions listed are evaluated for chronicity and support in the full medical record, such as history, medications, and final assessment. Results of HRA screening portions are not considered confirmed diagnoses unless supported by the final assessment documentation. Do not submit HRA forms that do not document a face-to-face encounter. The provider documentation of dated patient vitals is one element that supports a face-to-face encounter.”

- 2. Refer to the 360 compliance guidelines by following the link below.

[360 Compliance Guidelines Final](#)

VIII. HMR Best Practices

1. Refer to the HMR compliance guidelines by following the link below.

[HMR Compliance Guidelines Final](#)

IX. Resources and Source Documents

1. [FAQ Supplemental Document](#)
2. [Acceptable & Unacceptable Signatures \(CMS\)](#)
3. [Acceptable Physician Specialty List](#)
4. [Chapters 6 and 7 CMS 2008 Risk Adjustment Data Technical Assistance](#)
5. [AHIMA -LEGAL GUIDELINES FOR HANDLING CORRECTIONS, ERRORS, OMISSIONS, AND OTHER DOCUMENTATION PROBLEMS](#)

X. Appendix A Summary of Changes

Version	Date	Page	Section	Revision
1.0	8/2/17	10	Abstracting inpatient documents in a provider office record	Added language that outpatient coding guidelines should be applied
		14-15	Tobacco Use/Dependence	Edited section title to Tobacco Use/Dependence and removed 'abuse'; Edited code guidance for "Smoking" for which no code exists. Edited table header to Use and removed Abuse; Edited table under Tobacco Use and removed abuse; Added Tobacco Abuse to table with language that a code does not exist
1.2	1/5/18	4	Abbreviations	Added HRA and language around 360 and EE
		5	Diagnosis Code Abstraction	Updated #1, #5 language and added #6 and #7 to table
		6	Chronic Conditions	Added exclusive language for prospective coding initiative/ Updated sentence in #2 to states "order" labs./Changed Congestive Heart Failure to Heart Failure (if not stated as acute)
		7	Patient Identifiers	Revised #3 for clarity
		7	Provider Specialties	Added Acceptable Credentials for CNS, APR-CNS, & Psych CNS under nurse practitioner; Unacceptable credentials for: Licensed Professional Counselor (LPC)
		8	Provider Identifiers and Signatures	Added 9 new acceptable EMR phrases/ Added 4 new unacceptable EMR phrases; Revised guidelines pertinent to provider credential placement; Revised guidelines for placement of credentials
		9	Acceptable/Unacceptable Document Sources	Added the word "forms" next to referral.
		10	Date of Service	Rephrased #3 for clarity
		11	Abstracting Inpatient documents found in provider record	Added letter C under Operative Report to further explain acceptable code abstraction.
		12	Abstracting from SOAP notes	Added exclusion language for prospective coding initiatives
		13	"With" or "In"	Added new guidance around the word 'in'
		15	Uncertain Diagnosis	Added 3 additional terms: consistent with, compatible with, and indicative of
		17	Malignant Neoplasm	Added #3 for active vs. hx of cancer
		20-21	Diabetes	Added new linkage term "in"/ Added letter "c" under Diabetes and use of insulin and oral hypoglycemic drugs. Added guidance around diabetic retinopathy; Added linkage term 'in'; Guidance for long-term medications
		23	Cardiology	Added new MI types; Added new list of types of heart failure. (non-exhaustive); Added new list of terms associated with heart failure
		25	BMI and Nutritional Diagnoses	Add guidance when to code capture BMI
		27	Prospective (360) Best Practices	Added guidance around code abstraction on a health risk assessment
28	Prospective and HMR Compliance	Updated links		
1.3	2/1/19	4	Abbreviations	Added DOS and DOB
		5	Scope of coder	Added language
		5	Diagnosis code abstraction	Added language to treatment plans
		7	Patient identifiers	Revised language
		8	Unacceptable Specialty List	PharmD added to list
		10	Provider Identifiers	Added language
		10	Signatures and credentials	Added language for co-signatures, addendums
		11	Date of service	Revised language for EMR pagination issues
		12	Scribe	Inserted guidelines from CMS
		13	Abstracting IP documents in OP setting	Added PT/OT Inpatient Therapy Notes to "do not code"
		17	Uncertain Diagnoses	Added new terms on uncertain list
		18	Tobacco Abuse	Added check mark in table and removed "no code available"
		20	CVA/TIA	Updated title and language to include acute MI's and Sepsis
		20	Medication List	Revised language to apply only to Insulin
		22	Diabetes	Added language for using additional codes; AHA coding clinic resource/ Add comma as unacceptable linkage term
		24	Incidental findings	Added section
		27-28	BMI	Added language/classification
31	Resources and Source Documents	Removed Medication List and AHIMA Scribe link / OSCR Error Flags document added		