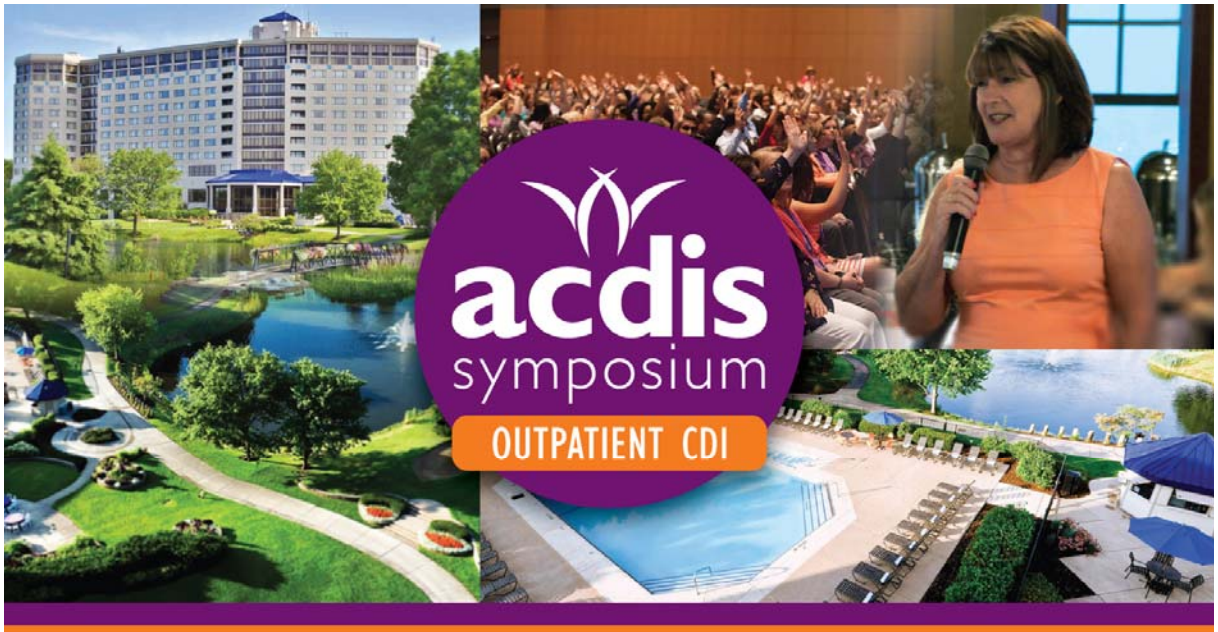

Risk Adjustment: Where's Waldo?
Common Diagnoses Often Missed in Outpatient Documentation

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HCPro
an H3.Group brand

Program Notes for CDI Outpatient Workshop Series

acdis
Association of Clinical Documentation Improvement Specialists

- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
  - https://acdis.org/2017-outpatient-cdi-workshop
- Continuing education information
  - Please note: In order to receive your continuing education certificate(s) for this workshop series, you must complete the online evaluation, which can be found in the CE instructions file on the download page. The evaluation will open after the last event in the *entire* series on November 17, 2017.

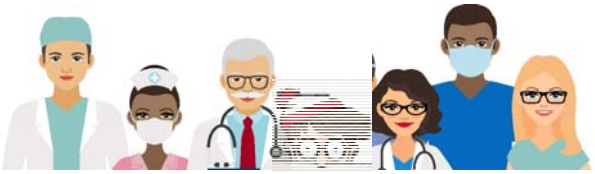
Where's Waldo?
Common Diagnoses Often Missed in Outpatient Documentation

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Discuss the concept of risk adjustment, identifying what types of diagnoses likely contribute to risk score
  - Identify documentation needed to allow a diagnosis to be reported
  - Identify clinical indicators supporting query opportunities for diagnoses commonly found in the Medicare population

Physician Visits: Tick-Tock

- The average physician office visit is less than 15 minutes.
- Physicians start by asking patients how they are and why they came in, trying to zero in on the "chief complaint."
- “Medical schools drill students in the art of taking a careful medical history, but studies have found doctors often fall short in the listening department. It turns out they have a bad habit of interrupting.”



Roni Caryn Rabin: You're on the Clock: Doctors Rush Patients Out the Door. Kaiser Health News April, 2014

“Time Well Spent?”

- When in the examination room with patients, physicians spent 52.9% of their time directly talking with patients and 37% of their time on EHR and other desk work
- Desk work included reviewing test results, logging information, writing medication orders, and other tasks

Roni Caryn Rabin: You're on the Clock: Doctors Rush Patients Out the Door. Kaiser Health News April, 2014

Are we missing diagnoses? Are we sighting the Waldos?

- **It is easy to overlook what is right in front of you when you are rushed and have multiple demands upon your time**
  - Providers may fail to document secondary diagnoses that don't *appear* important or related to the encounter
  - Coders may choose not to report a diagnosis because they feel it does not meet the reportable diagnosis criteria

Risk Adjustment

- **Risk adjustment is used to modify payment based on the health status and demographic characteristics of an enrollee**
- **Risk adjustment is used to weight quality measures**
- **Risk scores measure individual beneficiaries' relative risk, allowing payment adjustments for each beneficiary's expected expenditures**

Risk Adjustment: The Value of Chronic Conditions

- The CMS-HCC model is prospective in the sense that it uses diagnosis information from a base year to predict costs or risks for the next year
- It is largely driven by:
  - The costs associated with chronic diseases
  - The systematic risk (costs) associated with Medicare populations

Risk Adjustment: The Value of Chronic Conditions

- Providers should document any and all diagnoses related to a condition. They should discuss the relationships between the conditions and the considerations made in planning the care and treatment.
- Often chronic diseases are overlooked in documentation as the providers don't necessarily consider them impactful. Or if they are mentioned, they are not reported because the coders don't see them as reportable.

Reportable Diagnoses

- M - Monitored
- E - Evaluated
- A - Assessed
- T - Treated

T - Treatment
A - Assessment
M - Monitor/Medicate
P - Plan
E - Evaluate
R - Refer

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Medical Decision-Making Is Often Invisible

- Documentation of medical decision-making
  - Identify all problems managed or addressed during each encounter;
  - Identify problems as stable or progressing, when appropriate;
  - Indicate differential diagnoses when the problem remains undefined;
  - Indicate the management/treatment option(s) for each problem; and
  - Note management options to be continued somewhere in the progress note for that encounter (e.g., medication list) when documentation indicates a continuation of current management options (e.g., "continue meds")

Medical Decision-Making Serves Up the MEAT

Patient seen today for complaints of intermittent chest pain. History includes coronary atherosclerosis, heart failure, and pulmonary embolism. Patient states he is frequently using antacids with moderate relief. EKG demonstrates normal sinus rhythm, with occasional PVC. Cardiac enzymes negative x 2, chest x-ray WNL. Medications include Lasix, propranolol, and Coumadin.

Assessment/Plan: Chest pain due to GERD, with possible esophagitis. Pepcid AC prescribed. Follow up with GI specialist for further evaluation and EGD.

What diagnoses can be reported?

Medical Decision-Making Serves Up the MEAT

Patient seen today for complaints of intermittent chest pain. History includes coronary atherosclerosis, heart failure, and pulmonary embolism. Patient states he is frequently using antacids with moderate relief. EKG demonstrates normal sinus rhythm, with occasional PVC. Cardiac enzymes negative x 2, chest x-ray WNL. Medications include Lasix, propranolol, and Coumadin.

Assessment/Plan: Chest pain due to GERD, with possible esophagitis. Pepcid AC prescribed. Follow up with GI specialist for further evaluation and EGD.

What diagnoses can be reported?

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mrs. Smith seen today to assess status of pressure ulcer on left hip. Despite persistent efforts of treatment, necrosis is evident through to the subcutaneous tissue with increase drainage noted. Ten-pound weight loss since last visit, with loss of significant muscle mass. Assessment: Stage three pressure ulcer of left hip with significant necrosis of tissue.

Plan: Refer to wound care clinic for treatment and debridement. Physical therapy ordered to assist with conditioning and strength exercise.

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mrs. Smith seen today to assess status of pressure ulcer on left hip. Despite persistent efforts of treatment, necrosis is evident through to the subcutaneous tissue with increase drainage noted. Ten-pound weight loss since last visit, with loss of significant muscle mass. Assessment: Stage three pressure ulcer of left hip with significant necrosis of tissue.

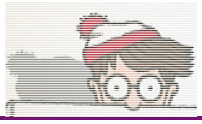
Plan: Refer to wound care clinic for treatment and debridement. Physical therapy ordered to assist with conditioning and strength exercise.

Query for Malnutrition
HCC 21

Malnutrition (E40–E46)

- Protein-energy malnutrition is the most common form of nutritional deficiency among patients who are hospitalized in the United States
- In some studies, the protein-energy malnutrition prevalence among elderly persons is estimated to be
  - As high as 4% for those living in the community
  - 50% for those hospitalized in acute care units or geriatric rehabilitation units
  - 30%–40% for those in long-term care facilities

Malnutrition (E40–E46)



- In elderly persons, an indicative sign of malnutrition is delayed healing and an increased presence of decubitus ulcers of stage 3 or higher
- In developed countries, inadequate food intake is a less common cause of malnutrition; protein-energy malnutrition is more often caused by decreased absorption or abnormal metabolism
  - In developed countries, diseases such as cystic fibrosis, chronic renal failure, childhood malignancies, congenital heart disease, and neuromuscular diseases contribute to malnutrition

HCC 21
Protein-Calorie Malnutrition

- E41 Nutritional marasmus
- E42 Marasmic kwashiorkor
- E43 Unspecified severe protein-calorie ma
- E44.0 Moderate protein-calorie malnutriti
- E44.1 Mild protein-calorie malnutrition
- E45 Retarded development following PCM
- E46 Unspecified protein-calorie malnutriti
- E64.0 Sequelae of protein-calorie malnutri
- R64 Cachexia or wasting syndrome

Inclusion Terms:

- Retarded development following PCM (E45)
  - Nutritional short stature
  - Nutritional stunting
  - Physical retardation due to malnutrition
- Unspecified PCM (E46)
  - Malnutrition NOS
  - Protein-calorie imbalance, NOS

Malnutrition Criteria

- Some consider albumin and pre-albumin levels imprecise indicators of malnutrition, so new criteria were established and published in the May 2012 *Journal of the Academy of Nutrition and Dietetics*
  - Consensus statement of the American Academy of Nutrition and Dietetics (the Academy) and the American Society for Parental and Enteral Nutrition (ASPEN)
    - ASPEN is an organization comprised of healthcare professionals representing the disciplines of medicine, nursing, pharmacy, dietetics, and nutrition science

Malnutrition – ASPEN Criteria

- The guidelines indicate that malnutrition should be diagnosed when at least two or more of the following six characteristics are identified:
  - Insufficient energy intake
  - Weight loss
  - Loss of muscle mass
  - Loss of subcutaneous fat
  - Localized or generalized fluid accumulation that may sometimes mask weight loss
  - Diminished functional status as measured by hand grip strength

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mr. Waldo is seen for his annual wellness exam. He is disabled due to pain related to a catapult injury two years ago. Insulin-dependent diabetic with peripheral neuropathy. Hypertensive chronic kidney disease and heart failure. Medications include: insulin, Monopril, MS Contin 120 mg/day. He states pain management remains an issue; medication does not appear to be working as well to cover pain. A1C has improved to 9.5, with diet changes and better management with insulin. Complaints of constipation, started on docusate. We will …

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

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Query for Opioid Dependency HCC 55

Opioid Dependency

- **Physical dependence** describes state related to habitual use of a drug, where the patient would experience negative physical withdrawal symptoms if the medication were to be abruptly discontinued. Drug dependency is characterized by a psychological craving for a drug.
- **Symptoms of withdrawal:** nausea, cramps, sweating, chills, vomiting, diarrhea, shakes, irritability, agitation, anxiety, muscle pain, insomnia, dilated pupils.

Coding Clinic Guidance

Question:

What is the code assignment when the physician documents "opioid dependence with continuous use for chronic low back pain and sciatica"?

Answer:

Any type of drug dependency (i.e., prescribed, non-prescribed [illicit], physiological, and/or behavioral) is coded as drug dependence. If the provider does not indicate drug dependence for continuous use of a prescribed narcotic, assign the appropriate code identifying long-term (current) use of other medications.

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mrs. O'Leary lives alone, spouse died one year ago, depression diagnosed shortly after. She is seen today with complaints of cough, congestion, and shortness of breath with exertion and intermittent chills. CXR indicates an infiltrate in left lower lobe. White count elevated. History includes hypertension, atrial fibrillation, diet-controlled diabetes, depression, and insomnia. No change in medication history, which includes atenolol, Coumadin, and Wellbutrin XL. She states Wellbutrin working well. Prescription called for Levaquin, and instructions given for cough suppressant and Tylenol as needed.

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

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Query for specificity of the depression: HCC 58

HCC 58
Major Depressive Disorder: Single Episode

- Agitated depression
- Depressive reaction
- Major depression
- Psychogenic depression
- Reactive depression
- Vital depression

Specify:
- Mild, moderate, severe
- With/without psychoses
- Partial/full remission

Not included:
- Atypical depression
- Post-schizophrenic depression
- Depression NOS
- Depressive disorder NOS
- Major depression, unspecified

HCC 58
Major Depressive Disorder: Recurrent

- Depressive reaction
- Endogenous depression
- Major depression
- Psychogenic depression
- Reactive depression
- Seasonal depression
- Vital depression

Specify:
- Mild, moderate, severe
- With/without psychoses
- Partial/full remission

Major Depressive Disorder

- **Major depression has a high rate of coexistence with disorders such as panic disorder, post-traumatic stress disorder, generalized anxiety disorder, agoraphobia, social phobia, and substance abuse**
- In the elderly, physical illness is highly correlated with major depression
- **Other conditions associated with major depression include pharmacological (steroid use, amphetamine/ cocaine/alcohol/sedative withdrawal), endocrine (hypothyroidism and hyperthyroidism, diabetes, Cushing's disease), infectious (general paresis, influenza, hepatitis, AIDS), or neurological (multiple sclerosis, Parkinson's disease, head trauma, cerebrovascular disorder) and personality disorders**

Major Depressive Disorder

Single episode (F32.-)

- Mild (CC)
- Moderate (CC)
- Severe (with & without psychotic features) (CC)
- In partial and in full remission
- Major depression, NOS

Recurrent (F33.-)

- Mild (CC)
- Moderate (CC)
- Severe (with & without psychotic features) (CC)
- In remission, unspecified (CC)
  - Partial and full
- Major depressive disorder (CC)
  - Recurrent, unspecified
  - Monopolar depression, NOS

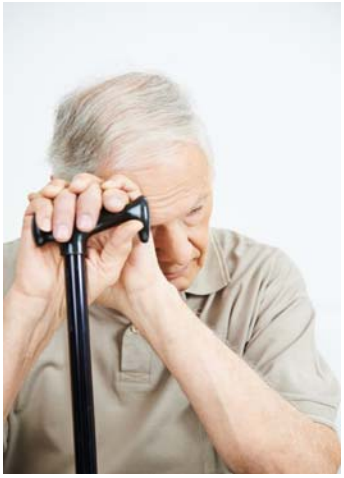
Major Depressive Disorder
Single Episode: Diagnostic Criteria

Subjective or objective reporting of:

- Depressed mood most of the day, nearly every day
- And/or loss of interest or pleasure in almost all activities most of the day, nearly every day
- And at least four or more of the symptoms listed on the following slide, not related to effects of a substance use or bereavement or attributed to another medical problem

Major Depressive Disorder
Single Episode

- Significant weight loss/gain
  - ± 5% of body weight within a month
- Insomnia or hypersomnia
- Psychomotor agitation as noted by others
- Fatigue or energy loss nearly every day
- Feelings of worthlessness, inappropriate guilt
- Diminished ability to concentrate or focus
- Recurrent thoughts of death/suicidal ideation



MDD Levels of Severity

Column A	Column B
Depressed mood	Loss of self-esteem/confidence
Lack of interest and enjoyment in daily activities	Feelings of guilt and unworthiness
Reduced energy/decreased activity	Pessimistic thought
	Disturbed sleep
	Diminished appetite
	Ideas of self-harm

Mild:
- **1 from column A**
- **1–2 from column B**

Moderate:
- **> 1 from column A**
- **2–3 from column B**

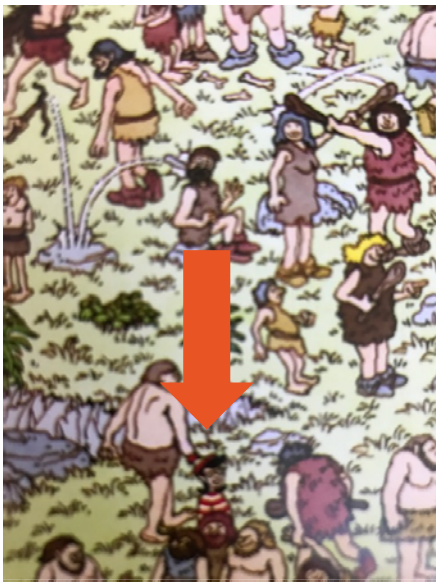
Severe:
- **3 from column A**
- **> 3 from column B**

MDD Levels of Severity
Functional Impairment Considerations

Functional Domain	Moderately Impaired	Severely Impaired
Family relationships	Quiet, negative, oppositional	Withdrawn, won't talk
School/work	Grades, work performance deteriorating, missing/cutting class or work, work stress	Falling performance, missing school or work, oppositional, high academic or work stress
Peer relationships	Decreased socializing, increased time on computer	Isolated, discontinued extracurricular activities
Stress level/anxiety	Minimizes or denies issues, projects onto others, blames others	Withholds feelings, won't talk
Suicidal ideation	Vague/occasional	Frequent, has plan, hx attempts
Other self-harm	Occasional thoughts/no attempts	Cutting/other self-injury

Major Depressive Disorder: Recurrent

- The course of the illness tends to vary. Some people experience bouts of depression separated by years between episodes in which there are no symptoms. Others may have periods of several episodes. Still others may have more and more occurrences as they age.



Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mr. Phinney is seen today for a 12-month follow-up related to the history of prostate cancer and prostatectomy. No signs of reoccurrence noted, PSA levels of no concern. I have encouraged him to lose weight to assist with control of his diabetes and hypertension. He has gained 35 pounds since his surgery last year related to inactivity. Plan includes a session with dietitian and therapist. No change in existing medications, with an addition of Xenical.

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mr. Phinney is seen today for a 12-month follow-up related to the history of prostate cancer and prostatectomy. No signs of reoccurrence noted, PSA levels of no concern. I have encouraged him to lose weight to assist with control of his diabetes and hypertension. He has gained 35 pounds since his surgery last year related to inactivity. Plan includes a session with dietitian and therapist. No change in existing medications, with an addition of Xenical.

Query opportunity: Morbid Obesity HCC 22

HCC 22: Morbid Obesity

- E66.01 Morbid obesity due to excess calories
- E66.2 Morbid obesity with alveolar hypoventilation
  - Includes Pickwickian syndrome
- BMI codes
  - Z68.41 BMI 40.0–44.9, adult
  - Z68.42 BMI 45.0–49.9, adult
  - Z68.43 BMI 50.0–59.9, adult
  - Z68.44 BMI 60.0–69.9, adult
  - Z68.45 BMI 70 or greater, adult

E66 Overweight and obesity

Code first obesity complicating pregnancy, childbirth and the puerperium, if applicable (O99.21-)

Use additional code to identify body mass index (BMI), if known (Z68.-)

Excludes1: adiposogenital dystrophy (E23.6)
lipomatosis NOS (E88.2)
lipomatosis dolorosa [Dercum] (E88.2)
Prader-Willi syndrome (Q87.1)

E66.0 Obesity due to excess calories

E66.01 Morbid (severe) obesity due to excess calories

Excludes1: morbid (severe) obesity with alveolar hypoventilation (E66.2)

E66.09 Other obesity due to excess calories

E66.1 Drug-induced obesity

Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

E66.2 Morbid (severe) obesity with alveolar hypoventilation
Pickwickian syndrome

E66.3 Overweight

E66.8 Other obesity

E66.9 Obesity, unspecified
Obesity NOS

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mrs. Waldo returns today for evaluation after her left hip repair s/p fracture six weeks ago. She has been tolerating her physical therapy well and demonstrating improved range of motion. Glucose levels have been well controlled. Restarted on Coumadin with INR now maintained at 2.0 for history of DVT right leg two years ago. History includes diabetes, COPD, osteoporosis, and nicotine dependence.

Physical assessment demonstrates edema of right leg, with small ulcer noted; dark scab present. Patient encouraged to continue to wear compression stocking and elevate when at rest … smoking cessation counseling provided.

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mrs. Waldo returns today for evaluation after her left hip repair s/p fracture six weeks ago. She has been tolerating her physical therapy well and demonstrating improved range of motion. Glucose levels have been well controlled. Restarted on Coumadin with INR now maintained at 2.0 for history of DVT right leg two years ago. History includes diabetes, COPD, osteoporosis, and nicotine dependence.

Physical assessment demonstrates edema of right leg, with small ulcer noted; dark scab present. Patient encouraged to continue to wear compression stocking and elevate when at rest … smoking cessation counseling provided.

Query for: Post-Thrombotic Syndrome (HCC 107) or Chronic DVT (HCC 108)?

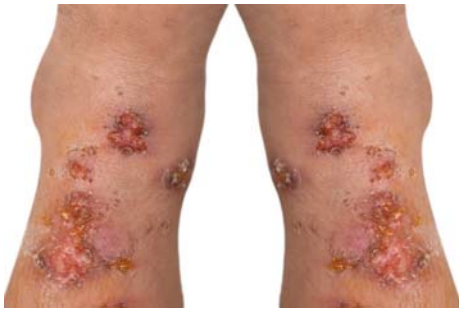
HCC 107
Vascular Disease with Complications

- Post-thrombotic syndrome
  - Develops in nearly half of all patients who experience a deep vein thrombosis in the leg. PTS symptoms include chronic leg pain, swelling, redness, and ulcers.
  - Chronic venous insufficiency following DVT.
  - Treatment: anticoagulants, elevation of extremities, compression stockings, weight loss, exercise.

Only codes identifying ulcer only (I87.01) and with ulcer and inflammation (I87.03-) are assigned to this HCC

Venous Ulcers (Stasis Ulcers)

- Risk factors: age, obesity, previous leg injuries, DVT, and phlebitis.
- Appear with irregular borders, shallow, and located over bony prominences. Granulation tissue and fibrin are typically present in the ulcer base.



Venous Ulcers (Stasis Ulcers)

- Associated findings include lower extremity varicosities, edema, venous dermatitis, and lipodermatosclerosis.
- Usually recurrent, and an open ulcer can persist for weeks to many years. Severe complications include cellulitis, osteomyelitis, and malignant change.

Treatment includes:

- **Leg elevation**
- **Compression therapy dressings**
- **Pentoxifylline & aspirin therapy**
- **Surgical management may be considered for ulcers that are large in size, of prolonged duration, or refractory to conservative measures**

Chronic DVT

- A clot that is over one to two months old is called "chronic." The clot becomes harder and scars the vein. The scar tissue tightens the lumen of the vein. The vein becomes much smaller and does not allow blood to flow through effectively.

Symptoms of chronic DVT

- Patients with chronic DVT experience leg swelling, pain, and often skin discoloration of the leg below the knee. These patients are typically prescribed compression stockings in order to help with these symptoms. These symptoms are related to the vein being blocked and not allowing blood flow out of the leg.

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mr. Grey was transported to the office today by ambulance. He required an excisional debridement of a stage 4 sacral pressure ulcer. Lung sounds clear, abdominal sounds noted in all four quadrants. Attendant says he tolerates his tube feedings well; family is very involved in the care of this bedridden patient. Baseline mental status demonstrates no change: end-stage dementia. Due to contractures of all four extremities, physical therapy no longer needed. Home health will coordinate follow-up with wound care …

Where's Waldo? Missing Diagnosis? Where Is the Query Opportunity?

Documentation states:

Mr. Grey was transported to the office today by ambulance. He required an excisional debridement of a stage 4 sacral pressure ulcer. Lung sounds clear, abdominal sounds noted in all four quadrants. Attendant says he tolerates his tube feedings well; family is very involved in the care of this bedridden patient. Baseline mental status demonstrates no change: end-stage dementia. Due to contractures of all four extremities, physical therapy no longer needed. Home health will coordinate follow-up with wound care …

Query for Functional Quadriplegia: HCC 70

HCC 70: Functional Quadriplegia (R53.2)

- Complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the brain or spinal cord
- Often seen in severe dementia, when patients do not have the mental functioning to move themselves and require "total care"
- Often described as "complete care," "bedridden," "total assist"

CDI Focus: Functional Quadriplegia

- This diagnosis should be rarely used and should have corroborating documentation from other disciplines such as physical therapy
- Patients with functional quadriplegia are not those who require only assistance with activities of daily living; rather, they are those who are extremely contractured and unable to extend or move their limbs
- This diagnosis is quickly becoming an audit target due to overuse on patients who are unable to self-care, but have the use of all of their extremities

Finding Waldo in the Outpatient Setting

Obstacles include:
Providers' lack of understanding of needed documentation
Limited time to assess & document care
Electronic health records—limited choices
Diagnosis capture not a traditional focus of outpatient coding practices
Large volume of records/limited resources for review/query follow-up

Thank you. Questions?

Lprescott@hcpro.com

To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

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Thank You!

The next program in the
Outpatient CDI Workshop series,

Novant Health Ambulatory CDI:
My How We've Grown!

will be broadcast live on
Wednesday, November 3 at 1 p.m. ET.