Ambulatory Clinical Documentation Improvement (aCDI)

Specialty Practice Toolkit

This toolkit is designed to provide a standard set of strategies and tools specific to help you improve care provided in the ambulatory environment. The toolkit has a three tiered approach that we believe provides a foundation for improvement work resulting in effective adoption and sustainability. These elements include:

1. **Infrastructure**: this first section focuses on the role of the care team and highlights how to prepare for upcoming appointments, optimize the role of team members, address equipment needs or medical record needs as well as how to regularly monitor your results;

2. **Competencies**: this section identifies what trainings are available to build clinical and content knowledge for all members of the care team and the patient population. Whenever possible hyperlinks to web based handouts, tools or webinars are included.

3. **Additional Resources**: We recognize that every team has different needs, and there are many resources available to browse and utilize as you see fit.

**Need help implementing this Toolkit?**

The MaineHealth ACO Improvement team can assist you with strategies and workflows in support of ACO initiatives. To learn more about what toolkits and Best Practice Frameworks are available or for improvement support please contact

Michele Gilliam, Director, Performance Improvement, at

MGilliam@mmc.org

or (207) 661-3804
**Ambulatory Clinical Documentation Improvement (aCDI) *Specialty***

1. Infrastructure:

- **Pre-Visit Planning/Huddle**
  - ✔️ Pre-visit check list
  - ✔️ Example of huddle tool

- **Define Care Team Roles**
  - ✔️ Sample workflow
  - ✔️ Talking points “Why aCDI”

- **EMR Tool / Documentation Tools**
  - ✔️ Risk Adjustment Documentation Guide
  - ✔️ HCC Reference Guides & “Cheat Sheets”
  - ___ EPIC BPA, enhancements (if applicable)

- **Regularly Measure Results (Sustainability)**
  - ✔️ HCC / Coding Gap Reports (via Arcadia or EPIC)
  - ✔️ KPI examples for performance improvement

***for most updated version of this packet, please visit www.mainehealthaco.org ***

Rev 2.26.19
**Huddle Sheet**

- What can we proactively anticipate and plan for in our work day/week? At the beginning of the day, hold a review of the day, review of the coming week and review of the next week. Frequency of daily review is dependent on the situation, but a mid-day review is also helpful.
- This worksheet can be modified to add more detail to the content and purpose of the huddles.

<table>
<thead>
<tr>
<th>Huddle Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice: ___________________________ Date: ___________________________</td>
</tr>
</tbody>
</table>

**Aim:** Enable the practice to proactively anticipate and plan actions based on patient need and available resources, and contingency planning.

**Follow-ups from Yesterday**

**“Heads up” for Today:** (include review for orders, labs, etc.; special patient needs, sick calls, staff flexibility, contingency plans)

<table>
<thead>
<tr>
<th>Meetings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity to note ‘coding gaps’ here</td>
</tr>
</tbody>
</table>

**Review of Tomorrow and Proactive Planning**

<table>
<thead>
<tr>
<th>Meetings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity to note ‘coding gaps’ here</td>
</tr>
<tr>
<td>Adult Prevention: Gap(s) in Care or Due Soon:</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>□ BMI (ht &amp; wt)</td>
</tr>
<tr>
<td>□ Blood Pressure (if &gt;140/90) pull last 3 BP</td>
</tr>
<tr>
<td>□ Falls Risk (65+)</td>
</tr>
<tr>
<td>□ Pneumococcal</td>
</tr>
<tr>
<td>□ Flu Shot</td>
</tr>
<tr>
<td>□ TDap</td>
</tr>
<tr>
<td>□ Tobacco Use/Counsel/Referral to MTHL</td>
</tr>
<tr>
<td>□ Depression Screen</td>
</tr>
<tr>
<td>□ Pap Smear</td>
</tr>
<tr>
<td>□ DEXA Scan</td>
</tr>
<tr>
<td>□ Colon Cancer Screen (50-75)</td>
</tr>
<tr>
<td>□ Breast Cancer Screen (50-75)</td>
</tr>
<tr>
<td>□ Outside Reports / Tests</td>
</tr>
<tr>
<td>□ Advance Directive</td>
</tr>
<tr>
<td>□ Outstanding Testing</td>
</tr>
<tr>
<td>□ Hospital Admissions/ED Visits</td>
</tr>
</tbody>
</table>

**NOTES:** current coding gaps?

<table>
<thead>
<tr>
<th>Cardiovascular Disease: Gap(s) in Care or Due Soon:</th>
<th>Controlled Substance: Gap(s) in Care or Due Soon:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Blood Pressure</td>
<td>□ Controlled Substance Agreement</td>
</tr>
<tr>
<td>□ IVD / Aspirin</td>
<td>□ UTOX</td>
</tr>
<tr>
<td>□ HTN</td>
<td>□ PMP</td>
</tr>
<tr>
<td>□ HF / Beta Blocker</td>
<td>□ Outstanding Testing</td>
</tr>
<tr>
<td>□ LDL</td>
<td>□ Hospital Admissions/ED Visits</td>
</tr>
<tr>
<td>□ Outside Reports / Tests</td>
<td></td>
</tr>
<tr>
<td>□ Outstanding Testing</td>
<td></td>
</tr>
<tr>
<td>□ Hospital Admissions/ED Visits</td>
<td></td>
</tr>
</tbody>
</table>

**NOTES:** current coding gaps?

<table>
<thead>
<tr>
<th>Pediatric Prevention: Gap(s) in Care or Due Soon:</th>
<th>Pediatric Asthma: Gap(s) in Care or Due Soon:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ BMI (ht &amp; wt)</td>
<td>□ Severity</td>
</tr>
<tr>
<td>□ 5-2-1-0</td>
<td>□ Controller Med</td>
</tr>
<tr>
<td>□ Immunizations</td>
<td>□ Action Plan</td>
</tr>
<tr>
<td>□ Tobacco Use/Exposure/Counsel/Referral to MTHL</td>
<td>□ Lung Function Test</td>
</tr>
<tr>
<td>□ Blood Pressure</td>
<td>□ Tobacco Use/Counsel/Referral to MTHL</td>
</tr>
<tr>
<td>□ Depression Screening</td>
<td>□ ACT</td>
</tr>
<tr>
<td>□ MCHAT/ASQ</td>
<td>□ Outside Reports / Tests</td>
</tr>
<tr>
<td>□ Outside Reports / Tests</td>
<td>□ BMI (ht &amp; wt)</td>
</tr>
<tr>
<td>□ Outstanding Testing</td>
<td>□ Outstanding Testing</td>
</tr>
<tr>
<td>□ Hospital Admissions/ED Visits</td>
<td>□ Hospital Admissions/ED Visits</td>
</tr>
</tbody>
</table>

**NOTES:** current coding gaps?

**Room Set Up Needs/General Notes:**

```
Pre-Visit Planning Checklist

Patient: _______________________ Reason for Appt: _______________________ Appt Time: __________

Adult Prevention: Gap(s) in Care or Due Soon:
- BMI (ht & wt)
- Blood Pressure (if >140/90) pull last 3 BP
- Falls Risk (65+)
- Pneumococcal
- Flu Shot
- TDaP
- Tobacco Use/Counsel/Referral to MTHL
- Depression Screen
- Pap Smear
- DEXA Scan
- Colon Cancer Screen (50-75)
- Breast Cancer Screen (50-75)
- Outside Reports / Tests
- Advance Directive
- Outstanding Testing
- Hospital Admissions/ED Visits

NOTES: current coding gaps?

Diabetic: Gap(s) in Care or Due Soon:
- HgbA1c
- Tobacco Use/Counsel/Referral to MTHL
- Micro albumin
- Outside Reports / Tests
- Eye Exam
- Foot Exam
- Depression Screen
- LDL
- Outstanding Testing
- Hospital Admissions/ED Visits

NOTES: current coding gaps?

Cardiovascular Disease: Gap(s) in Care or Due Soon:
- Blood Pressure
- IVD / Aspirin
- HTN
- HF / Beta Blocker
- LDL
- Outside Reports / Tests
- Outstanding Testing
- Hospital Admissions/ED Visits

NOTES: current coding gaps?

Controlled Substance: Gap(s) in Care or Due Soon:
- Controlled Substance Agreement
- UTOX
- PMP
- Outstanding Testing
- Hospital Admissions/ED Visits

NOTES: current coding gaps?

Pediatric Prevention: Gap(s) in Care or Due Soon:
- BMI (ht & wt)
- 5-2-1-0
- Immunizations
- Tobacco Use/Exposure/Counsel/Referral to MTHL
- Blood Pressure
- Depression Screening
- MCHAT/ASQ
- Outside Reports / Tests
- Outstanding Testing
- Hospital Admissions/ED Visits

NOTES: current coding gaps?

Pediatric Asthma: Gap(s) in Care or Due Soon:
- Severity
- Controller Med
- Action Plan
- Lung Function Test
- Tobacco Use/Counsel/Referral to MTHL
- ACT
- Outside Reports / Tests
- BMI (ht & wt)
- Outstanding Testing
- Hospital Admissions/ED Visits

NOTES: current coding gaps?

Room Set Up Needs/General Notes:

Rev 2.26.19
```
**aCDI / HCC Coding Gaps Specialty Practice Workflow**

### Pre Meeting / Meeting

- **Receive Gap Report**
  - Filter report based upon your specialty
  - *see SPECIALTY recommendations*

### Pre-visit / During Visit

- **Review Data (Gaps)**
  - Review / Validate / Edit Data
  - Does patient have an upcoming appointment?
    - **YES**
      - Outreach to patient to schedule new appointment
    - **NO**
      - Review patients with gaps during huddles/meetings
- **Note gaps on appointment or visit**
  - Review patients with gaps during huddles/meetings
- **Review patients with gaps during huddles/meetings**
  - Note (review) gaps prior to or during patient visit, proceed accordingly
  - Were all gaps closed during visit?
    - **YES**
      - Close note with follow up instructions as appropriate
    - **NO**
      - Amend chart / note to reflect correct documentation

### Wrap-up / Post-visit

- **Schedule Next Appointment (follow-up)**
- **Review note for completeness / appropriateness of documentation**
- **Did the documentation meet requirements?**
  - **YES**
  - **Submit claim to payer for processing**
  - **NO**
  - Review note for completeness / appropriateness of documentation

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**Staffing models vary.**
Care Teams are encouraged to decide "who" will do "what", by "when" during team meetings.
Once determined, teams can move on to the Pre-Visit / Visit activities.
Ambulatory Clinical Documentation Improvement

...Why?
More specific ICD-10 coding can lead to a more accurate RAF score and a clearer portrait of a patient’s health.
Why is Documentation Important?

**For Patients**
- Unlocks health plan benefits based on severity of condition:
  - No-cost preventive services and care management
  - Lower or waived co-pays for some medical services

**For Providers**
- Better communication with care team
- Better performance on quality measures
- Incentive revenue available to fund practice resources
- Impacts data used for public reporting
Why is Documentation Important to Care Teams?

This work:

- allows providers to wrap a code around the nebulous but important work that we do AND struggle to show/quantify

- decreases the struggle felt by RN/MA/other staff when completing pre-certs/ prior auths, DME paperwork when conditions are not documented or updated

<table>
<thead>
<tr>
<th>Private Practice</th>
<th>Hospital Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct bottom-line impact via reimbursement</td>
<td>Indirect impact- multiple providers not coding to specificity collectively affects organizational bottom line overall</td>
</tr>
</tbody>
</table>

_In either scenario, you play a vital part in the sustainability of your organization’s future!_
Why is Documentation Important to a Patient?

It’s more important than we think!

This work:

✓ Means that I may not have to wait two weeks for that MRI to be approved while I sit in pain, feeling anxious, etc.

✓ Means that I can have orthotics for free instead of choosing between orthotics or the power bill, adequate food, etc.

✓ Means that I could make appointments or get needed tests without concern for co-pays or deductibles

✓ Means that I can get the medications you prescribed to me—faster. Less delay in my progress toward better health!
The Big Picture

Optimal coding = better shared savings and patient benefit opportunities

Optimal coding:
- $32,726
  - Payer
  - Your Organization
  - Patient

Generic coding:
- $5,741
  - Payer
  - Your Organization
  - Patient

MHACO

MaineHealth Accountable Care Organization
The Big Picture

REIMBURSEMENT

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)

REPUTATION

Performance Categories

- Quality
- Improvement Activities
- Cost
- Advancing Care Information

- Your coding will impact the claims data used by CMS to produce your publicly reported performance.
- CMS uses risk scores to adjust several reimbursement programs.

MaineHealth Accountable Care Organization
KPI Example:

Measure and Celebrate Success

<table>
<thead>
<tr>
<th>Project Description:</th>
<th>Overall Progress:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease coding gaps from 23% to 15% by 09/30/2019 for Medicare Advantage and MSSP beneficiaries by implementing MHACO’s 2019 aCDI tactics</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Milestones</th>
<th>Measures of Success</th>
<th>Date Due</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Research &amp; Identify Priority Tactics</td>
<td>Conducted regional and national research on strategies to decrease coding gaps in the ambulatory care setting</td>
<td>11/30/18</td>
<td>100%</td>
</tr>
<tr>
<td>Solicit Input &amp; Obtain Endorsement</td>
<td>Gathered feedback from various stakeholders</td>
<td>1/31/19</td>
<td>50%</td>
</tr>
<tr>
<td>Implement Test of Change</td>
<td>Pilot tactics &amp; workflows at primary care sites</td>
<td>2/28/19</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Don’t forget to celebrate!**
- Celebrate your hard work
- Celebrate improved patient care and experience
- Celebrate increased reimbursement
2. Clinical Competencies:

- **Provider**
  - ✔️ Required Training: Three Simple Ways to Improve Clinical Documentation
    - [https://mainehealthaco.org/CDI](https://mainehealthaco.org/CDI)
  - ✔️ Care Team Roles – Provider

- **Staff**
  - ✔️ The Impact of Documentation on Patient Care
    - *(contact MHACO Improvement Advisor to schedule)*
  - ✔️ aCDI Webinars and Training:
    - [mainehealthaco.org/CDI](http://mainehealthaco.org/CDI)
    - *("Clinical Documentation Improvement" section)*

- **Build Staff Training Into Annual Competencies / Staff Orientation**
Training information and videos can be found at [https://mainehealthaco.org/CDI](https://mainehealthaco.org/CDI)

Clinical Documentation Improvement Training and Resources

- Training
- Resources

Clinical Documentation Improvement Training

The ACO’s Conditions of Participation require that all participating providers attend a clinical documentation improvement training before the end of 2019.

To access and complete the required training online and on-demand, please follow these instructions:

- Go to MaineHealth continuing medical education page here: [https://mainehealth.cloud-cme.com/default.aspx](https://mainehealth.cloud-cme.com/default.aspx)
- Sign in or create an account
- Click the “Online Courses” tab
- Scroll or search for the training entitled “Three Simple Ways to Improve Clinical Documentation”
- Click “Details” button
- Click “Tests”
- Click “Media”
- Watch training video and complete post-test and evaluation
### ROLES AND RESPONSIBILITIES: MEDICARE WELLNESS VISIT USING TEAM-BASED CARE MODEL

<table>
<thead>
<tr>
<th>POP HEALTH</th>
<th>CLERICAL SUPPORT</th>
<th>CLINICAL SUPPORT</th>
<th>PROVIDER</th>
</tr>
</thead>
</table>
| **Generate reports identifying patients with MC FFS or MA plans who have not had an MWV in past 12 months** | **Patient request Welcome to Medicare or Annual Wellness visit = Medicare Wellness Visit** | **Scan schedule for MC FFS or MA patient with follow-up visits scheduled:**  
1) MWV in past year?  
2) Can visit be extended to MWV?  
→ Schedule MWV (Note the visit type as either):  
1) Welcome to Medicare  
2) Medicare Annual Visit; Initial or Subsequent | **Review Problem list and assess potential diagnosis coding to highest level of specificity** |
| **Conduct outreach to patients encouraging MWV (mail, phone or Patient Portal)** | **→ Medicare Wellness Visit Patient Packet (See hand out) either:**  
1) Mail to patient  
2) Have patient come in 15 minutes early to complete  
3) MyChart** | **View visit type and update EMR (pull correct templates)**  
**Identify gaps in care/standing orders**  
**Welcome to Medicare?**  
1) EKG? (optional)  
(ck w/provider)** | |
| **PREVISIT PLANNING** | **DURING VISIT** | **POST VISIT** | **Check out:**  
- Schedule Next MWV  
  One year + One day out  
- Provide AVS | |
2. Additional Resources:

- Documentation Quick Guide: “MEAT” and “LOST”
- Top 10 Coding Conditions
- Payer Incentive Resources
- Coding “Cheat Sheets” for Primary and Specialty Care
  (for the most up-to-date ICD10 codes and guidelines, always refer to your latest ICD10 Coding book)
- Recommendations for Filtering Gap Reports
• 1 element required per Dx code; more is better
• These factors help providers to establish the presence of a diagnosis during an encounter (“if it wasn’t documented, it doesn’t exist”)
• Review problem list, document as ‘current’ or ‘active’
• Do not use ‘history of’ for chronic conditions unless is fully resolved. Instead use ‘stable

• Document anything that impacts your medical decision making to reflect the complexity and level of care provided.
• Documentation improves care, coverage, costs and compliance.
• other commonly lost conditions: substance/alcohol abuse, AIDS or HIV, mental health severity and status.
Some of the top Hierarchical conditions (HCC*) weighted by prevalence that is suggested to focus on could include:

<table>
<thead>
<tr>
<th>1. DM with Comp</th>
<th>6. Rheumatoid Arthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Specified Heart Arrhythmias</td>
<td>7. Major Depression</td>
</tr>
<tr>
<td>3. COPD</td>
<td>8. Metastatic Cancers</td>
</tr>
<tr>
<td>5. CHF</td>
<td>10. Amputations</td>
</tr>
</tbody>
</table>

*HCC - Hierarchical Condition Categories, CMS identified 79 Categories of medical conditions that map to a corresponding group of 9,500 ICD-10 diagnosis codes, pertains to ambulatory care and inpatient care.

** National Association of ACOs (NAACOS) suggest focusing on top 9 HCCs by weighted prevalence - MHACO has been following these HCCs and have added amputations.
If your patient has any of these problems, document the diagnosis, assessment, and plan, and report the corresponding code annually.

<table>
<thead>
<tr>
<th>Examples</th>
<th>ICD-10</th>
<th>HCC1</th>
<th>HCC weight²</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 diabetes (T2D)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T2D without complications</td>
<td>E11.9</td>
<td>19</td>
<td>0.104</td>
<td>Always has HCC weight. Document as specifically as possible.</td>
</tr>
<tr>
<td>T2D with hyperglycemia</td>
<td>E11.65</td>
<td>18</td>
<td>0.318</td>
<td></td>
</tr>
<tr>
<td>T2D with hypoglycemia, no coma</td>
<td>E11.649</td>
<td>18</td>
<td>0.318</td>
<td></td>
</tr>
<tr>
<td>T2D with mild retinopathy</td>
<td>E11.329</td>
<td>18</td>
<td>0.318</td>
<td></td>
</tr>
<tr>
<td>T2D with diabetic chronic kidney disease (CKD)</td>
<td>E11.22</td>
<td>18</td>
<td>0.318</td>
<td></td>
</tr>
<tr>
<td>T2D with polyneuropathy</td>
<td>E11.42</td>
<td>18</td>
<td>0.3168</td>
<td></td>
</tr>
<tr>
<td>Long term (current) insulin use</td>
<td>Z79.4</td>
<td>19</td>
<td>0.104</td>
<td></td>
</tr>
<tr>
<td>Hypertension (HTN)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTN with congestive heart failure (CHF)</td>
<td>I11.0</td>
<td>85</td>
<td>0.323</td>
<td>Isolated essential HTN has no HCC weight. Relationship must be explicitly documented.</td>
</tr>
<tr>
<td>HTN + CKD stage 5/end stage renal disease (ESRD)</td>
<td>I12.0</td>
<td>136</td>
<td>0.237</td>
<td></td>
</tr>
<tr>
<td>HTN + CHF + CKD stage 1-4</td>
<td>I13.0</td>
<td>85</td>
<td>0.323</td>
<td></td>
</tr>
<tr>
<td>HTN + CHF + CKD stage 5/ESRD</td>
<td>I13.2</td>
<td>85</td>
<td>0.323</td>
<td></td>
</tr>
<tr>
<td>HTN + heart disease (no CHF) + CKD 5/ESRD</td>
<td>I13.11</td>
<td>136</td>
<td>0.237</td>
<td></td>
</tr>
<tr>
<td>Chronic kidney disease (CKD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKD stage 4, glomerular filtration rate (GFR)</td>
<td>N18.4</td>
<td>137</td>
<td>0.237</td>
<td>No HCC weight unless stage 4 or worse, or associated with HIV.</td>
</tr>
<tr>
<td>CKD stage 5, GFR &lt;15</td>
<td>N18.5</td>
<td>136</td>
<td>0.237</td>
<td></td>
</tr>
<tr>
<td>ESRD</td>
<td>N18.6</td>
<td>136</td>
<td>0.237</td>
<td></td>
</tr>
<tr>
<td>Major infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>B20</td>
<td>1</td>
<td>0.312</td>
<td>Active infections — serious, systemic, opportunistic, or bone/joint/muscle.</td>
</tr>
<tr>
<td>Sepsis</td>
<td>A41.8</td>
<td>2</td>
<td>0.455</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td>C50.9</td>
<td>12</td>
<td>0.146</td>
<td>Active cancers — new, under treatment, or treatment declines — with documentation of any metastases.</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>C61</td>
<td>12</td>
<td>0.146</td>
<td></td>
</tr>
<tr>
<td>Lung, gastrointestinal, or pancreatic cancers</td>
<td>Varies</td>
<td>9</td>
<td>0.970</td>
<td></td>
</tr>
<tr>
<td>Metastasis to lymph nodes</td>
<td>C77.X</td>
<td>8</td>
<td>2.625</td>
<td></td>
</tr>
<tr>
<td>Hematologic problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myelodysplastic syndrome</td>
<td>D46.9</td>
<td>46</td>
<td>1.388</td>
<td></td>
</tr>
<tr>
<td>Aplastic anemia</td>
<td>D61.9</td>
<td>46</td>
<td>1.388</td>
<td></td>
</tr>
<tr>
<td>Acquired coagulopathy</td>
<td>D68.4</td>
<td>48</td>
<td>0.221</td>
<td></td>
</tr>
<tr>
<td>Senile purpura</td>
<td>D69.2</td>
<td>48</td>
<td>0.221</td>
<td></td>
</tr>
<tr>
<td>Immune thrombocytopenic purpura</td>
<td>D69.3</td>
<td>48</td>
<td>0.221</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>D69.6</td>
<td>48</td>
<td>0.221</td>
<td></td>
</tr>
<tr>
<td>Morbid obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morbid obesity</td>
<td>E66.01</td>
<td>22</td>
<td>0.273</td>
<td>No HCC weight unless BMI is 40 or greater or there are comorbidities.</td>
</tr>
<tr>
<td>Code BMI if known</td>
<td>Z68.41-45</td>
<td>22</td>
<td>0.273</td>
<td></td>
</tr>
<tr>
<td>Malnutrition</td>
<td>E46</td>
<td>21</td>
<td>0.545</td>
<td>Malnutrition requires documentation of objective data (e.g., albumin less than 3.4) or subjective data (wasted appearance).</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------</td>
<td>--------</td>
<td>-------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Protein-calorie malnutrition</td>
<td>R64</td>
<td>21</td>
<td>0.545</td>
<td></td>
</tr>
<tr>
<td>Cachexia</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chronic lung disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker's cough</td>
<td>J41.0</td>
<td>111</td>
<td>0.328</td>
<td>Document specifically if possible (smoking history, chest computed tomography results, pulmonary function tests, etc.).</td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.X</td>
<td></td>
<td></td>
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<tr>
<td>Chronic obstructive pulmonary disease (COPD),</td>
<td>J44.X</td>
<td>111</td>
<td>0.328</td>
<td>*Also code Z99.81, dependent on supplemental oxygen.</td>
</tr>
<tr>
<td>other</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>COPD, unspecified</td>
<td>J44.9</td>
<td>111</td>
<td>0.328</td>
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<tr>
<td>Pulmonary fibrosis</td>
<td>J84.10</td>
<td>112</td>
<td>0.209</td>
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<tr>
<td>Chronic respiratory failure</td>
<td>J96.10*</td>
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<tr>
<td>Inflammatory bowel disease</td>
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<tr>
<td>Crohn's disease</td>
<td>K50.90</td>
<td>35</td>
<td>0.294</td>
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<tr>
<td>Ulcerative colitis</td>
<td>K51.90</td>
<td>35</td>
<td>0.294</td>
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<tr>
<td>Chronic hepatitis</td>
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<td></td>
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<td></td>
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<tr>
<td>Chronic hepatitis C</td>
<td>B18.2</td>
<td>29</td>
<td>0.165</td>
<td></td>
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<tr>
<td>Chronic hepatitis, unspecified</td>
<td>K73.9</td>
<td>29</td>
<td>0.165</td>
<td></td>
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<tr>
<td>Cirrhosis</td>
<td></td>
<td></td>
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<tr>
<td>Alcoholic cirrhosis</td>
<td>K70.30</td>
<td>28</td>
<td>0.390</td>
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<tr>
<td>Non-alcoholic cirrhosis</td>
<td>K74.60</td>
<td>28</td>
<td>0.390</td>
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<tr>
<td>Esophageal varices, no bleed</td>
<td>I85.00</td>
<td>27</td>
<td>0.962</td>
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<tr>
<td>Portal hypertension</td>
<td>K76.6</td>
<td>27</td>
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<tr>
<td>Chronic pancreatitis</td>
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<tr>
<td>Chronic pancreatitis</td>
<td>K86.1</td>
<td>34</td>
<td>0.276</td>
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<tr>
<td>Rheumatologic problems</td>
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<td></td>
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<tr>
<td>Lupus</td>
<td>M32.9</td>
<td>40</td>
<td>0.423</td>
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<tr>
<td>Sicca syndrome (Sjoren)</td>
<td>M35.00</td>
<td>40</td>
<td>0.423</td>
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<tr>
<td>Rheumatoid arthritis</td>
<td>M06.9</td>
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<td>Inflammatory polyarthropathy</td>
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<tr>
<td>Polymalgia rheumatica</td>
<td>M35.3</td>
<td>40</td>
<td>0.423</td>
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<tr>
<td>Psychiatric problems</td>
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<tr>
<td>Schizophrenia</td>
<td>F20.9</td>
<td>57</td>
<td>0.608</td>
<td>“Run-of-the-mill” depression/anxiety has no HCC weight.</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>F25.9</td>
<td>57</td>
<td>0.608</td>
<td>Must document Diagnostic and Statistical Manual of Mental Disorders criteria.</td>
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<tr>
<td>Major depression, recurrent</td>
<td>F33.9</td>
<td>58</td>
<td>0.395</td>
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<tr>
<td>Bipolar disorder</td>
<td>F31.9</td>
<td>58</td>
<td>0.395</td>
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<tr>
<td>Alcoholism</td>
<td>F10.20</td>
<td>55</td>
<td>0.383</td>
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<tr>
<td>Alcoholism, in remission</td>
<td>F10.21</td>
<td>55</td>
<td>0.383</td>
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<tr>
<td>Drug dependence</td>
<td>F1X.20</td>
<td>55</td>
<td>0.383</td>
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<tr>
<td>Drug dependence, in remission</td>
<td>F1X.21</td>
<td>55</td>
<td>0.383</td>
<td></td>
</tr>
<tr>
<td>Neurologic problems</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Parkinson's disease</td>
<td>G20</td>
<td>78</td>
<td>0.585</td>
<td>Remember to list these chronic diseases annually, even if primary management is by a consultant.</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>G35</td>
<td>77</td>
<td>0.441</td>
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<tr>
<td>Paralysis</td>
<td>G83.9</td>
<td>104</td>
<td>0.395</td>
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<tr>
<td>Seizure disorder</td>
<td>G40.909</td>
<td>79</td>
<td>0.227</td>
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<tr>
<td>Ischemic stroke</td>
<td>Varies</td>
<td>100</td>
<td>0.265</td>
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</tr>
<tr>
<td>Cardiac disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------------</td>
<td>---</td>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>Angina</td>
<td>I20.9</td>
<td>88</td>
<td>0.140</td>
<td></td>
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<tr>
<td>Coronary artery disease with angina</td>
<td>I25.119</td>
<td>88</td>
<td>0.140</td>
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<tr>
<td>Unstable angina</td>
<td>I20.0</td>
<td>87</td>
<td>0.218</td>
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<tr>
<td>Acute myocardial infarction</td>
<td>I21.3</td>
<td>86</td>
<td>0.233</td>
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<tr>
<td>Pulmonary hypertension</td>
<td>I27.2</td>
<td>85</td>
<td>0.323</td>
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<tr>
<td>Cor pulmonale</td>
<td>I27.81</td>
<td>85</td>
<td>0.323</td>
<td></td>
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<tr>
<td>Cardiomyopathy</td>
<td>I42.9</td>
<td>85</td>
<td>0.323</td>
<td></td>
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<tr>
<td>CHF</td>
<td>I50.9</td>
<td>85</td>
<td>0.323</td>
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<tr>
<td>Atrial fibrillation</td>
<td>I48.91</td>
<td>96</td>
<td>0.268</td>
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<tr>
<td>Aortic atherosclerosis</td>
<td>I70.0</td>
<td>108</td>
<td>0.298</td>
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<tr>
<td>Abdominal aortic aneurysm</td>
<td>I71.4</td>
<td>108</td>
<td>0.298</td>
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<table>
<thead>
<tr>
<th>Deep venous thrombosis (DVT)</th>
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</thead>
<tbody>
<tr>
<td>DVT, acute</td>
<td>I82.40</td>
<td>108</td>
<td>0.298</td>
</tr>
<tr>
<td>DVT, chronic</td>
<td>I82.50</td>
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<table>
<thead>
<tr>
<th>Vascular disease</th>
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<tbody>
<tr>
<td>Peripheral vascular disease</td>
<td>I73.9</td>
<td>108</td>
<td>0.298</td>
</tr>
<tr>
<td>Diabetic peripheral vascular disease</td>
<td>E11.51</td>
<td>18</td>
<td>0.318</td>
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<tr>
<td>Venous stasis ulcers with varicose veins</td>
<td>I83.0</td>
<td>107</td>
<td>0.400</td>
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<tr>
<td>Chronic venous stasis ulcer</td>
<td>I87.31</td>
<td>107</td>
<td>0.400</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ophthalmology</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Wet macular degeneration</td>
<td>H35.32</td>
<td>124</td>
<td>0.499</td>
</tr>
<tr>
<td>Proliferative diabetic retinopathy</td>
<td>H35.32</td>
<td>124</td>
<td>0.499</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Trauma</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Concussion w/o loss of consciousness, sequelae</td>
<td>S06.0X0S</td>
<td>167</td>
<td>0.191</td>
</tr>
<tr>
<td>Head injury with subdural hemorrhage</td>
<td>S06.6X6A</td>
<td>166</td>
<td>0.584</td>
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<tr>
<td>Hip fracture</td>
<td>S72.009A</td>
<td>170</td>
<td>0.418</td>
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<table>
<thead>
<tr>
<th>Artificial openings</th>
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<tbody>
<tr>
<td>Tracheostomy status</td>
<td>Z93.0</td>
<td>82</td>
<td>1.055</td>
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<tr>
<td>Gastrostomy status</td>
<td>Z93.1</td>
<td>188</td>
<td>0.571</td>
</tr>
<tr>
<td>Colostomy status</td>
<td>Z93.3</td>
<td>188</td>
<td>0.571</td>
</tr>
<tr>
<td>Cystostomy status</td>
<td>Z93.5</td>
<td>188</td>
<td>0.571</td>
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</table>

<table>
<thead>
<tr>
<th>Amputation status</th>
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<tbody>
<tr>
<td>Specify site</td>
<td>Z89.4-6</td>
<td>189</td>
<td>0.588</td>
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</table>

<table>
<thead>
<tr>
<th>Major organ transplant</th>
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</thead>
<tbody>
<tr>
<td>Heart transplant status</td>
<td>Z94.1</td>
<td>186</td>
<td>1.000</td>
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<tr>
<td>Lung transplant status</td>
<td>Z94.2</td>
<td>186</td>
<td>1.000</td>
</tr>
<tr>
<td>Liver transplant status</td>
<td>Z94.4</td>
<td>186</td>
<td>1.000</td>
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</table>

<table>
<thead>
<tr>
<th>Excluded chronic conditions</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential hypertension, hyperthyroidism or hypothyroidism, iron deficiency anemia, gastroesophageal reflux, osteoarthritis, and tobacco use.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypertension
I10 Essential, Primary
I15.8 Secondary, Other

With CKD
I12.9 Hypertensive CKD (stage 1-4) & N18.x Stage of CKD

With heart disease & CKD w/heart failure
I13.0 Hypertensive heart & CKD w/CHF & stage 1-4 CKD & N18.x Stage of CKD & I50.xx CHF code (see below)

I13.2 Hypertensive heart & CKD w/CHF & stage 5 or ESRD & N18.x Stage of CKD & I50.xx CHF code (see below)

With heart disease & CKD without heart failure
I13.10 with stage 1-4 or unspecified CKD & N18.x CKD stage
I13.11 with stage 5 CKD or ESRD & N18.x CKD stage

With Heart disease
I11.9 Hypertensive heart disease without heart failure

With Heart Failure
I11.0 Hypertensive heart disease w/heart failure & I50.xx CHF code

Congestive heart failure
I50.41 acute combined systolic & diastolic
I50.43 acute on chronic combined systolic & diastolic
I50.42 chronic combined systolic & diastolic
I50.31 acute diastolic
I50.33 acute on chronic diastolic
I50.32 chronic diastolic
I50.21 acute systolic
I50.23 acute on chronic systolic
I50.22 chronic systolic
I50.1 Left Ventricular

Chronic Heart Disease
I25.5 Ischemic cardiomyopathy
I25.6 Silent myocardial ischemia
I25.89 Other forms ischemic heart disease
I51.89 Functional chronic ischemic heart disease
I52 Chronic ischemic heart disease in diseases classified elsewhere (include disease)
I27.1 Kyphoscoliotic chronic ischemic heart disease
I27.81 Chronic cor pulmonale
I27.82 Chronic pulmonary embolism

Cardiomyopathy
I42.0 congestive
I42.5 constrictive
I42.0 dilated
I42.7 due to drug/external agent
I43 in diseases classified elsewhere (also include disease)
I42.2 nonobstructive hypertrophic
I42.1 obstructive hypertrophic
I42.2 other hypertrophic
I42.8 other cardiomyopathy
I42.9 primary, NOS
I42.9 secondary, NOS

Coronary Atherosclerosis
I25.82 with complete/total occlusion
I25.83 due to lipid rich plaque
I25.84 due to calcified coronary lesion

Autologous Artery Bypass
with angina pectoris
I25.728 other forms
I25.729 unspecified
I25.72Ø unstable
I25.721 with documented spasm
I25.81Ø without angina pectoris

Autologous Vein Bypass
with angina pectoris
I25.718 other forms
I25.719 unspecified
I25.71Ø unstable
I25.711 with documented spasm
I25.81Ø without angina pectoris

Native Artery
with angina pectoris
I25.118 other forms
I25.119 unspecified
I25.11Ø unstable
I25.111 with documented spasm
I25.1Ø without angina pectoris

Nonautologous Biological Bypass
with angina pectoris
I25.738 other forms
I25.739 unspecified
I25.73Ø unstable
I25.731 with documented spasm
I25.81Ø without angina pectoris

I25.2 OLD MI (> 28 days)

Aneurysm (>4.4)
I71.2 thoracic aorta, without rupture
I71.6 thoraco-abdominal aorta, without rupture
I71.9 aorta, unspecified site, without rupture
I25.41 coronary Artery
I25.3 heart (wall)
I72.5 precerebral arteries
I72.6 vertebral artery
I28.1 pulmonary Artery
I25.3 ventricular

Aortic Ectasia/Dilation (>3.9 <4.4)
I77.81Ø thoracic aorta
I77.812 thoracoabdominal aorta
I77.819 unspecified site, aorta
### TYPE 2 DIABETES Coding

<table>
<thead>
<tr>
<th><strong>with circulatory complications</strong></th>
<th><strong>with neurological complications</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.52 PVD/peripheral angiopathy with gangrene</td>
<td>E11.44 amyotrophy</td>
</tr>
<tr>
<td>E11.51 PVD/peripheral angiopathy without gangrene</td>
<td>E11.43 autonomic (poly) neuropathy</td>
</tr>
<tr>
<td>E11.59 other</td>
<td>E11.41 mononeuropathy</td>
</tr>
<tr>
<td><strong>E11.65 with hyperglycemia</strong></td>
<td><strong>E11.49 neurological complications</strong></td>
</tr>
<tr>
<td><strong>with hypoglycemia</strong></td>
<td>E11.42 polyneuropathy</td>
</tr>
<tr>
<td>E11.641 with coma</td>
<td><strong>with opthalmic complications</strong></td>
</tr>
<tr>
<td>E11.649 without coma</td>
<td>E11.36 cataract</td>
</tr>
<tr>
<td><strong>with kidney complications</strong></td>
<td><strong>with arthropathy</strong></td>
</tr>
<tr>
<td>E11.22 chronic kidney disease</td>
<td>E11.61Ø neuropathic</td>
</tr>
<tr>
<td>E11.21 nephropathy</td>
<td>E11.618 other</td>
</tr>
<tr>
<td>E11.29 other</td>
<td><strong>E11.9 without complications</strong></td>
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<tr>
<td><strong>with skin complications</strong></td>
<td>09/2017 OCDS/RJB</td>
</tr>
<tr>
<td>E11.62Ø diabetic dermatitis</td>
<td><em><strong>see code book for retinopathy</strong></em></td>
</tr>
<tr>
<td>E11.621 foot ulcer</td>
<td><strong>with arthropathy</strong></td>
</tr>
<tr>
<td>E11.628 other skin complications</td>
<td>E11.61Ø neuropathic</td>
</tr>
<tr>
<td>E11.622 other skin ulcer</td>
<td>E11.618 other</td>
</tr>
<tr>
<td><strong>E11.630 with periodontal disease</strong></td>
<td><strong>E11.9 without complications</strong></td>
</tr>
</tbody>
</table>

Diabetes documentation should include:

- **Type of diabetes, Type 1, Type 2 or secondary.**
- **If secondary, document the cause or primary condition as it relates to the diabetes.**
- **Be sure to include DM with hyperglycemia/hypoglycemia if indicated (E11.65/E11.69).**

Documentation for diabetic complications:

- **The causal relationship should be clearly stated.** Phrases such as “due to”, “with”, “because of” or “related to” should be used to link the conditions.

**Example:**

- Diabetes with renal manifestation
  - Stage 3 chronic kidney disease due to Type 2 diabetes mellitus (N18.3, E11.22)
  - Diabetes mellitus, Type 2 with stage 3 chronic kidney disease (E11.22, N18.3)
- Diabetes uncontrolled with peripheral circulatory disorders
  - Gangrene of right great toe due to uncontrolled diabetic PVD (E11.65, E11.52)
- Diabetes uncontrolled with neurological manifestations
  - Polyneuropathy and diabetes due to diabetes, Type 2, uncontrolled (E11.65, E11.42)
# SUBSTANCE ABUSE, DEPENDENCE, USE

<table>
<thead>
<tr>
<th>DEPENDENCE</th>
<th>ABUSE/USE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol dependence</strong></td>
<td><strong>Alcohol</strong></td>
</tr>
<tr>
<td>F10.21 in remission</td>
<td>F10.10 Alcohol abuse uncomplicated</td>
</tr>
<tr>
<td>F10.20 uncomplicated</td>
<td>Alcohol use disorder, mild</td>
</tr>
<tr>
<td>F10.230 with withdrawal, uncomplicated</td>
<td><strong>Cocaine</strong></td>
</tr>
<tr>
<td>F10.232 with withdrawal, with perceptual disturbance</td>
<td>F14.10 Cocaine abuse uncomplicated</td>
</tr>
<tr>
<td><strong>Cocaine dependence</strong></td>
<td>Cocaine use disorder, mild</td>
</tr>
<tr>
<td>F14.21 in remission</td>
<td><strong>Opioid</strong></td>
</tr>
<tr>
<td>F14.20 uncomplicated</td>
<td>F11.10 Opioid abuse uncomplicated</td>
</tr>
<tr>
<td>F14.23 with withdrawal</td>
<td>Opioid use disorder, mild</td>
</tr>
<tr>
<td><strong>Opioid dependence</strong></td>
<td><strong>Polysubstance abuse</strong></td>
</tr>
<tr>
<td>F11.21 in remission</td>
<td>F19.10 Polysubstance abuse uncomplicated</td>
</tr>
<tr>
<td>F11.20 uncomplicated</td>
<td>Polysubstance use disorder, mild</td>
</tr>
<tr>
<td>F11.23 with withdrawal</td>
<td>Indiscriminant drug use, uncomplicated</td>
</tr>
<tr>
<td><strong>Polysubstance dependence</strong></td>
<td>Other or unknown substance use disorder, mild</td>
</tr>
<tr>
<td>F19.21 in remission</td>
<td><strong>Sedative, hypnotic, anxiolytic abuse</strong></td>
</tr>
<tr>
<td>F19.20 uncomplicated</td>
<td>F13.10 Sedative, hypnotic, anxiolytic abuse uncomplicated</td>
</tr>
<tr>
<td>F19.230 with withdrawal, uncomplicated</td>
<td>Sedative, hypnotic, anxiolytic use disorder, mild</td>
</tr>
<tr>
<td><strong>Sedative, hypnotic, anxiolytic dependence</strong></td>
<td><strong>Sedative, hypnotic, anxiolytic abuse</strong></td>
</tr>
<tr>
<td>F13.21 in remission</td>
<td>F13.21 with alcohol induced anxiety disorder (F10.280)</td>
</tr>
<tr>
<td>F13.20 uncomplicated</td>
<td>F13.20 with alcohol induced anxiety disorder (F10.180)</td>
</tr>
<tr>
<td>F13.230 with withdrawal, uncomplicated</td>
<td>F13.23 with alcohol induces anxiety disorder (F10.980)</td>
</tr>
<tr>
<td>F13.232 with withdrawal, with perceptual disturbance</td>
<td><strong>Related conditions/ complications:</strong></td>
</tr>
</tbody>
</table>

**Documentation related to Alcohol and Drugs should include:**

**Specificity:**

- All substances
- Is it use, abuse or dependence (see DSM-IV Substance Dependence Criteria)
- Is it current or in remission
  - Example:
    - Alcohol dependence, in remission (F10.21)
    - Alcohol abuse (F10.10)
    - Alcohol use disorder, mild (F10.10)
    - Alcohol use –Do not code, use only if a related psychoactive condition

**Related conditions/ complications:**

- The causal relationship should be clearly stated. Phrases such as “due to”, “with”, “because of” or “related to” should be used to link the conditions. (See code specificity next page)
  - Example:
    - Alcohol dependence with alcohol induced anxiety disorder (F10.280)
    - Alcohol abuse with alcohol induced anxiety disorder (F10.180)
    - Alcohol use with alcohol induces anxiety disorder (F10.980)
# Urology/Nephrology Coding

<table>
<thead>
<tr>
<th>Chronic Kidney Disease (see table for stage criteria)</th>
<th>BPH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Due to Diabetes</strong></td>
<td>N40.0 w/o lower urinary tract symptoms</td>
</tr>
<tr>
<td>E11.22 Type 2 DM with diabetic chronic kidney disease</td>
<td>N40.1 w/ lower urinary tract symptoms</td>
</tr>
<tr>
<td>Also add stage of CKD</td>
<td>N40.2 nodular w/ lower urinary tract symptoms</td>
</tr>
<tr>
<td>E11.21 Type 2 DM with diabetic nephropathy</td>
<td>N40.3 nodular w/ lower urinary tract symptoms</td>
</tr>
<tr>
<td><strong>Due to Hypertension</strong></td>
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</tr>
<tr>
<td>I12.9 Hypertensive CKD with stage I-IV CKD</td>
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<tr>
<td>Also add code for stage of CKD</td>
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</tr>
<tr>
<td>I12.0 Hypertensive CKD with stage 5 CKD or ESRD</td>
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<tr>
<td>Also add code for stage of CKD</td>
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<td><strong>Stage</strong></td>
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<td>N18.2 stage 2</td>
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<td>N18.4 stage 4</td>
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<td>N18.5 stage 5</td>
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<tr>
<td>N18.6 end stage renal disease (ESRD)</td>
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<tr>
<td>N18.9 stage unspecified</td>
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<td><strong>Z99.2 dependence on Dialysis</strong></td>
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<td><strong>Z91.15 noncompliance with Dialysis</strong></td>
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<tr>
<td><strong>Erectile Dysfunction</strong></td>
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<tr>
<td>N52.01 arterial insufficiency</td>
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<tr>
<td>N52.02 corporo-venous occlusive</td>
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<tr>
<td>N52.03 combined</td>
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</tr>
<tr>
<td>N52.1 due to diseases classified elsewhere (see below)</td>
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</tr>
<tr>
<td>N52.2 drug induced</td>
<td></td>
</tr>
<tr>
<td><strong>Due to Diabetes, also add N52.1 (ED d/t disease classified elsewhere)</strong></td>
<td>T83.022 _ nephrostomy</td>
</tr>
<tr>
<td>E11.59 Type 2 DM w/other circulatory complications</td>
<td>T83.021 _ urethral, indwelling</td>
</tr>
<tr>
<td>E11.40 Type 2 DM w/diabetic neuropathy, unspecified</td>
<td>T83.018 _ urinary, other</td>
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<tr>
<td><strong>Artificial Openings</strong></td>
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<td><strong>Cystostomy</strong></td>
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<tr>
<td>Z93.52 Appendico-vesicostomy status</td>
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</tr>
<tr>
<td>Z93.51 Cutaneous-vesicostomy status</td>
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<tr>
<td>Z93.59 Other cystostomy status</td>
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<tr>
<td>Z93.50 Unspecified cystostomy status</td>
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</tr>
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<td><strong>Other</strong></td>
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<td>Z93.6 Other artificial openings of urinary tract status</td>
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<td>(nephrostomy, ureterostomy, urethrostomy)</td>
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<tr>
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<td>* code must be completed based on encounter type initial (A), subsequent (D), sequela (S)</td>
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<td>T83.012 _ nephrostomy</td>
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<td>T83.011 _ urethral, indwelling</td>
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<td>T83.018 _ urinary, other</td>
<td></td>
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<tr>
<td><strong>Displacement</strong></td>
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<td>T83.022 _ nephrostomy</td>
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<td>T83.021 _ urethral, indwelling</td>
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<tr>
<td>T83.028 _ urinary, other</td>
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<tr>
<td><strong>Leakage</strong></td>
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<td>T83.032 _ nephrostomy</td>
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<td>T83.031 _ urethral, indwelling</td>
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</tr>
<tr>
<td>T83.038 _ urinary, other</td>
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</tr>
</tbody>
</table>

## Documentation for renal/urological complications:
- The causal relationship should be clearly stated. Phrases such as “due to”, “with”, “because of” or “related to” should be used to link the conditions.

**Example:**
- Chronic kidney disease due to Type 2 Diabetes--Type 2 Diabetes w/ chronic kidney disease (Same codes apply)
  - Stage 3 chronic kidney disease due to Type 2 diabetes mellitus (N18.3, E11.22)
  - Diabetes mellitus, Type 2 with stage 3 chronic kidney disease (E11.22, N18.3)
- Chronic kidney disease, stage 3 due to hypertension
  - Hypertensive chronic kidney disease with stage 1-4 CKD (I12.9, N18.3)
- Erectile dysfunction due to Type 2 Diabetes, specify if related to circulatory or neurological complication
  - Type 2 DM w/other circulatory complications & ED due to disease classified elsewhere (E11.59, N52.1)
  - Type 2 DM w/diabetic neuropathy, unspecified & ED due to disease classified elsewhere (E11.40, N52.1)

08/2017 OCDS/RJB
# Chronic Renal Disease Stage Table

<table>
<thead>
<tr>
<th>CKD</th>
<th>(Dx Code)</th>
<th>GFR</th>
<th>Approx Serum Creatinine</th>
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<tr>
<td>Stage 1</td>
<td>(N18.1)</td>
<td>&gt;90 w/kidney damage</td>
<td>&lt;0.9</td>
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<tr>
<td>Stage 2</td>
<td>(N18.2)</td>
<td>60-89 w/kidney damage</td>
<td>1.0-1.3</td>
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<tr>
<td>Stage 3</td>
<td>(N18.3)</td>
<td>30-59</td>
<td>1.4-2.4</td>
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<tr>
<td>Stage 4</td>
<td>(N18.4)</td>
<td>15-29</td>
<td>2.5-4.5</td>
</tr>
<tr>
<td>Stage 5</td>
<td>(N18.5)</td>
<td>&lt;15</td>
<td>&gt;4.5</td>
</tr>
<tr>
<td>ESRD</td>
<td>(N18.6)</td>
<td>N/A</td>
<td>Need for dialysis</td>
</tr>
</tbody>
</table>

## Formula for calculating approximated GFR

\[
\left[\frac{(140 - \text{age})}{\text{creatinine}} \times 0.85\right] = \text{approximate GFR}
\]
Fun with Filters!

A Specialty Guide
to “Working” Your HCC Coding Gap Lists
So You’ve Got the Report…

Sort OR Filter: By Practice --> By Provider
(this allows for care teams to have a clear picture of their own patient panel)

<table>
<thead>
<tr>
<th>Region</th>
<th>Practice</th>
<th>Provider</th>
<th>DOB</th>
<th>Race</th>
<th>Age</th>
<th>Sex</th>
<th>Unencoded Condition</th>
<th>Uncoded RAF</th>
<th>Last PCP Visit</th>
<th>HCC</th>
<th>DX Cod</th>
<th>Condition Category</th>
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<th>plan apo</th>
<th>visit Provider Name</th>
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</tr>
</tbody>
</table>

*TIP*
FILTER will produce only the data you choose in the dropdown menu
SORT will organize the data without excluding any information

Easily organized by care team
Sort vs. Filter

*TIP*
FILTER will produce only the data you choose in the dropdown menu
SORT will organize the data without excluding any information

In your gap report, click the upper left-most cell in order to highlight all data.

Next, click on the "Data" tab to explore options for organizing your patient gaps.
Results

By filtering (using the drop-down arrows in each column header) you can choose ONLY the pieces of data to show. In this example, we are choosing to ONLY view those patients with Diabetes and Heart Conditions.

By sorting (clicking the “sort” icon) you can organize data according to priority or viewing order. In this example, we are choosing to look at patients, by provider, organized by highest number of coding gaps to lowest number of coding gaps.

Specialty Practices: USE THIS OPTION

Most useful for quality or population health staff

Accountable Care Organization
Filtering – View an Example

Specialist Care Teams generally focus on a particular condition(s). In this case, filter by “condition”, and select those that apply.

(for example, if your team would like to focus first on those patients with COPD or “lung” conditions)

**in this example, perhaps the report is intended for an RN who supports two providers. The RN is able to view a report filtered by “provider” and “condition”

<table>
<thead>
<tr>
<th>Region</th>
<th>Practice</th>
<th>Provider</th>
<th>DU</th>
<th>Age</th>
<th>Sex</th>
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<th>Uncoded RAF</th>
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</tbody>
</table>
RECOMMENDATIONS FOR FILTERING/SORTING YOUR aCDI Report

You have received a Coding Gap Report, which includes information from claims data showing patient conditions that have not been coded (documented) during a visit in 2018. You will want to validate the information against your EMR. Here are some recommendations for making the list workable:

1. **Sort/Filter by**
   a. **PRACTICE**, then
   b. **PROVIDER**, then
   c. **UNCODED RAF** (Largest to Smallest)
   
   This allows you to break up the report, distribute to other members of the team.

   **OPTIONAL - Additional Filters to consider:**
   **CONDITIONS**
   - DM with Comp
   - Specified Heart Arrhythmias
   - COPD
   - Vascular Disease
   - CHF
   - Rheumatoid Arthritis
   - Major Depression
   - Metastatic Cancers
   - Morbid Obesity
   - Amputations

   Or **CONDITION CATEGORIES**
   - Amputation
   - Diabetes
   - Heart
   - Lung
   - Metabolic
   - Neoplasm
   - Psychiatric
   - Vascular

2. **Validate** through your EMR
   a. Is the patient deceased?*
   b. Is the patient Active
   c. Have they had a recent visit where codes were captured?

**NOTES:**
- **PHYSICIAN = HOSPITAL NPI:** These patients will need to be validated in your EMR as a first step; if you find a PCP is assigned in your EMR, replace PHYSICIAN field with that PCP’s name
- **PHYSICIAN = SPECIALIST:**
- **TROUBLE SCROLLING** through your workbook? Go to VIEW → FREEZE PANES → UNFREEZE PANE
**REPORT DEFINITIONS**

<table>
<thead>
<tr>
<th>Column</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>Community the patient has been attributed to (according to Health Plan)</td>
</tr>
<tr>
<td>Practice</td>
<td>Name of Practice</td>
</tr>
<tr>
<td>Provider</td>
<td>Provider patient is attributed to (according to Health Plan)</td>
</tr>
<tr>
<td>Name</td>
<td>Demographics</td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Uncoded Conditions</td>
<td>Any Condition that has not been coded in current performance year</td>
</tr>
<tr>
<td>Uncoded RAF</td>
<td>Total Risk score for all UNCODED Diagnoses</td>
</tr>
<tr>
<td>Last PCP Visit</td>
<td>Last visit per claims data</td>
</tr>
<tr>
<td>HCC</td>
<td>HCC Category of Uncoded Condition</td>
</tr>
<tr>
<td>DX Code</td>
<td>Diagnoses Code that has not been recaptured for current performance year</td>
</tr>
<tr>
<td>Condition</td>
<td>HCC Category name</td>
</tr>
<tr>
<td>Condition</td>
<td>HCC Category Description</td>
</tr>
<tr>
<td>Uncoded DX Risk Score</td>
<td>Risk score for Uncoded DX code</td>
</tr>
<tr>
<td>PlanPayer</td>
<td>Patients Insurance Carrier</td>
</tr>
<tr>
<td>Riskeventprovidername</td>
<td>Provider who last billed the DX Code</td>
</tr>
<tr>
<td>riskeventdate</td>
<td>Date of Service DX code was last billed</td>
</tr>
<tr>
<td>HCC</td>
<td>Hierarchical Condition Categories</td>
</tr>
<tr>
<td>RAF</td>
<td>Risk Adjustment Factor (Risk Score)</td>
</tr>
</tbody>
</table>

Ambulatory Clinical Documentation Improvement (aCDI) is a way for your Physicians to accurately reflect their patients’ acuity.

**RECOMMENDED TALKING POINTS: Why is this important?**

- **Patient:** Accurately reflecting the patient’s acuity will open up value added benefits for your patient with their insurance company.
- **Care Team:** Accurate documentation assists the care team with pre-visit planning, identify quality gaps to close, and prior authorization process is improved as notes are accurate meaning approval vs. denial and rework.
- **Physician:** Contractual benchmarks will be attainable as insurance companies will look at claims data to set cost and utilization benchmarks. Additionally, improving clinical documentation increases the practices shared savings opportunity.

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*We have done our best to remove deceased patients from the report; please note however, this information is not always captured on claims in a timely manner.*