Diagnosis Coding: Building the Case for Excellent Outcomes

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Learning Objectives

1. Identify how diagnosis documentation and optimization improves patient care and reimbursement

1. Explore the top 6 diagnoses in Primary Care and identify key barriers that challenge accurate coding

1. List three team based strategies to improve documentation, coding and billing within daily clinical operations
Disclosures

Regional Medical Director, Aledade Inc
What is your practice focused on right now?

Maintaining Independence
Keeping ownership of your practice, care delivery and how you get paid

Administrative Burdens
Checking boxes for payers, programs and multiple reporting requirements

Technology & Data
 Battling with costly technology that complicates workflows and doesn’t deliver helpful data or analytics

Patient Engagement
Reaching at-risk patients with limited resources and inadequate staff training

Financial Sustainability
Juggling declining reimbursement and minimal influence on payment

Workforce Shortages
Struggling to fill open positions and retain qualified staff
What is value-based care?

Value-based care is the concept that health care physicians should be paid for keeping people healthy rather than the volume of services delivered.

- Annual Wellness Visits
- Value-Based Care
- Health Screenings
- Immunizations
- Medication Adherence
The history of value-based care.

- 2010: The Affordable Care Act (ACA) was signed into law.
- 2012: The Medicare Shared Savings Program (MSSP) was launched with two tracks, along with other value-based care programs.
- 2016-2018: Additional program tracks were added to MSSP.
- 2019: CMS creates new MSSP program structure.
- 2021: CMS announces goal to have all Medicare beneficiaries in an accountable care relationship by 2030.
Because of MSSP success, by 2030, every Medicare beneficiary should be cared for by a physician in a value-based program.
Physician compensation is increasingly tied to quality outcomes.

The COVID-19 pandemic has accelerated the share of physician compensation tied to quality performance.

Medical groups tying physician compensation to quality

<table>
<thead>
<tr>
<th>Year</th>
<th>2019</th>
<th>2022</th>
<th>63% increase</th>
</tr>
</thead>
</table>

35% have reported they have increased the share of compensation tied to quality in the past two years.

Source: 2022 MGMA DataDive Provider Compensation
True North

Accurate and Complete Diagnosis Documentation:

✓ Drives essential care coordination for complex patients by ensuring practices are aware of conditions for which a patient may be receiving treatment at another site of care, and vice versa.

✓ Ensures patients receive high quality clinical care by increasing visibility into patient comorbidities, complications, and complexity.

✓ Gives practices credit for managing complex patients and increases the yearly reserve for care; accurate and complete diagnosis coding and documentation ensures an accurate financial benchmark.
Accurate, complete diagnosis coding is core to our mission

Our patients, practice partners, and the broader society rely on effective diagnosis coding.

**Patients**
- Diagnosis coding is fundamental to **knowing our patients** and “quarterbacking” their care across a fragmented healthcare ecosystem.

**Practices**
- Taking on financial risk for our patients requires we **correctly record our patients’ diagnoses** – or jeopardize our ability to provide the quality care patients deserve.

**Society**
- Policymakers, our business partners, and other healthcare stakeholders rely on us to **accurately document diagnoses**.
Diagnosis documentation enables care and prevention—across visits, teams, and systems.

Missed diagnoses are missed care opportunities:

- 8,849 patients with **Suicide Ideation/Attempt**… Only 75% with **Depression** diagnosed
- 57,191 w/ **Hypoxic Respiratory Failure**… Only 57% with **COPD** diagnosed
- 5,442 **Toe Amputations**… Only 49% had a **DM w/ Vascular comp.** diagnosis
- 77,257 **Acute Myocardial Infarctions**… Only 25% had **Vascular Disease** diagnosed

**Diagnosis documentation enables** care and prevention—across visits, teams, and systems.
What are we really talking about?

**Risk Stratification**: alignment of the right patients for the right clinical initiatives, according to their clinical diagnoses and burden of illness.

**Risk Adjustment**: methodology by which a payer uses demographic and diagnostic data to predict the healthcare costs a population of individuals should incur, actuarially.

**Diagnosis Documentation**: the health care providers’ contribution is to accurately and completely document their patients’ clinical conditions using Monitor, Evaluate, Assess or Treat (M.E.A.T.) criteria and submit the corresponding ICD-10 diagnoses on their claims.
“Wait a minute. I thought people could get in trouble for talking about this.”

There is nothing inherently wrong with risk adjustment or coaching practices to accurately and completely document and code diagnoses. It is a core principle of value based care. Insurers MUST calculate the expected cost of a population so they can understand the savings generated from better coordinated care.

Aledade does not incentivize coding of weighted diagnoses, nor push practices to uncover diagnoses for the purposes of risk inflation.
Ms. W. is a 76-year-old retired teacher.

She is an avid runner and coaches her 6-year-old granddaughter’s soccer team. She has been a vegetarian since she turned 40.

She has familial hypercholesterolemia and a history of breast cancer, for which she has completed treatment. Her only current medication is a statin, which she takes regularly using a pill-reminder app on her smartphone.

Ms. V. is a 76-year-old retired teacher.

She lives alone and seldom sees out of state family. She does not exercise on a regular basis and is a current smoker.

She has poorly controlled diabetes, hypertension, heart failure and vascular disease. She is prescribed seven medications, which she sometimes has trouble taking. She was seen in the ED several times last year, and she was admitted to the hospital five times.
How does risk stratification actually work?

A patient’s Risk Score is calculated to anticipate future cost of care.

- Age
- Sex
- Medicaid Dual Eligibility
- Disability Status

ICD-10 Diagnosis and Documentation

- CMS-HCCs

Patient Health Conditions

= Risk Score
### What is the impact of Accurate and Complete Diagnosis Coding?

<table>
<thead>
<tr>
<th>Ms. W: All Conditions Documented</th>
<th>Ms. V: No Conditions Documented (Demographics Only)</th>
<th>Ms. V: Some Conditions Documented</th>
<th>Ms. V: All Conditions Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year-old female</td>
<td>0.468</td>
<td>76 year-old female</td>
<td>0.468</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.177</td>
<td>Medicaid eligible</td>
<td>0.177</td>
</tr>
<tr>
<td>DM not coded</td>
<td>-</td>
<td>DM (no complications)</td>
<td>0.104</td>
</tr>
<tr>
<td>Vascular Disease not coded</td>
<td>-</td>
<td>Vascular Disease without complication</td>
<td>0.298</td>
</tr>
<tr>
<td>CHF not coded</td>
<td>-</td>
<td>CHF not coded</td>
<td>-</td>
</tr>
<tr>
<td>No interaction</td>
<td>-</td>
<td>No interaction</td>
<td>-</td>
</tr>
<tr>
<td>Patient Total RAF</td>
<td>0.645</td>
<td>Patient Total RAF</td>
<td>1.047</td>
</tr>
<tr>
<td>Yearly Reserve for Care</td>
<td>$4,680</td>
<td>Yearly Reserve for Care</td>
<td>$10,470</td>
</tr>
</tbody>
</table>

- **Difference of >$12,000 in Yearly Reserve for Care**
What can incomplete coding mean for health care savings?

Difference of $12,000 in Yearly Reserve for Care

To make up for that difference, a practice/provider would need to prevent...

1 hospital admission,¹

6 unnecessary ED visits,²

Or Reduce Skilled Nursing Facility (SNF) stay by 36 days³

¹ [https://www.hcup-us.ahrq.gov/reports/statbriefs/sb204-Most-Expensive-Hospital-Conditions.jsp](https://www.hcup-us.ahrq.gov/reports/statbriefs/sb204-Most-Expensive-Hospital-Conditions.jsp)
² [https://www.beckershospitalreview.com/eds/cost-of-er-visits-increased-31-between-2012-16-5-findings.html](https://www.beckershospitalreview.com/eds/cost-of-er-visits-increased-31-between-2012-16-5-findings.html)
Top Four Primary Care Diagnoses

The amount of new information we add to the system is concentrated in a small number of conditions.

Two-thirds of the Aledade-specific diagnostic contributions belong to the same four categories (almost exclusively diagnosed by PCPs):

- Major **Depression** and Paranoid Disorders
- **Morbid Obesity**
- **Vascular Disease**
- **Diabetes Mellitus** with Chronic Complications
Diagnosis Documentation Strategies

Shrink the Change!

1. Prioritize primary care sensitive conditions: depression, morbid obesity, diabetes with complications, vascular disease.
   - Screening for or checking on existing depression yields many downstream benefits and may prevent a catastrophic event.
   - Ensuring understanding of current disease state for any chronic condition helps catch worsening control before a poor outcome.

2. Use acute visits to check in on relevant chronic diseases.
   - “Glad we have a plan for your knee pain today. By the way, weight loss can be helpful for knee problems so I might suggest…”
     {address morbid obesity}
   - “It sure is hard to exercise when your knee has been hurting. How are your blood sugars doing with the decreased activity?”
     {address comorbid diabetes}
The 6 D’s of Diagnosis Documentation

The following “6Ds” are frequently incompletely or inaccurately documented and billed in patient populations.

**Diabetes**
- Type 2 DM and its complications are commonly seen in 65+ patients
  - e.g. CKD, Nephropathy, Neuropathy, Retinopathy, Gastroparesis, etc.
  - ICD10 guidelines assume a causal relationship between most complications regardless of linking language
- Diabetes poorly controlled may be monitored via FBS, HbA1c, eGFR can be indicative of hyperglycemic and other complications

**Depression**
- Please describe specificity of MDD - Major Depressive Disorder, documentation without the following specifics classify to ‘depression’, which is not included in RA models
  - Severity - mild, moderate, severe
  - Frequency - single, recurrent or remission

**“Diet” (Obesity/Morbid or Severe Obesity)**
- Overweight, Obesity/Morbid Obesity diagnoses are based on clinical judgement
- If higher BMI and additional comorbid conditions impact the patients overall health, the treating provider may clinically assess for Morbid Obesity
- BMI > 40 classifies as Morbidly Obese, ensure to report secondary Z code for BMI when clinically relevant
The 6 D’s of Diagnosis Documentation

**Drinking and Drugs**
- Alcohol & Substance Use, Abuse and Dependence are in your office everyday
- Screen, intervene, and make sure it is appropriately documented and coded according to DSM criteria for use/abuse/dependence

**Dementia**
- Cognitive decline could be due to underlying Alzheimer’s or Vascular Dementia

**Dyspnea**
- COPD
- Acute/Chronic Hypoxic Respiratory Failure (24/7 02)
- Bronchitis - Acute or Chronic
- Emphysema
- Asthma (Commercial Payers)
Depression Coding

1. Be specific with severity.
   Is it mild, moderate or severe?
   Use a PHQ-9 or your own clinical intuition
   Both are acceptable
   - Avoid F32.9 (Depression, single episode, unspecified)

2. Remember: Anxiety and Depression are two separate diagnoses
   - Avoid the imprecise F41.8 (“Anxiety with Depression”).

3. Remember to diagnose for Depression in Remission, if accurate.

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There is never a need to “upcode”
Just be precise
## Diagnosis and monitoring: PHQ-9

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the news, watching TV</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**PHQ-9 total score:**
<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Diagnosis</th>
</tr>
</thead>
</table>
| 0-4         | - If no prior history of Depression and being used for screening: No Diagnosis  
              - If there is a prior diagnosis of depression: Major Depression in Remission |
| 5-9         | Major Depression, mild |
| 10-14       | Major Depression, moderate |
| 15-19       | Major Depression, moderate or severe |
| 20-27       | Major Depression, severe |
Diabetes Coding

Document and code all chronic and co-existing conditions

- Link assessment, plan and medications to diagnoses

Example 1: Patient has DM, CKD, continue metformin and continue to work on exercise and diet, gfr 38 repeat labs in 3 mos. (E11.22, Type 2 DM with diabetic CKD, N18.32, CKD stage 3b)

Example 2: Type 1 DM, continue novolog and diabetic diet. (E10.9, Type 1 DM without complications)

Example 3: Patient has DM with HTN, continue glipizide and losartan, had annual eye exam will schedule with podiatrist for foot exam. (E11.59, Type 2 DM with other circulatory complications, I10, Essential (primary) hypertension)
Diabetes “with”

Under the term “with,” there are instances where a causal relationship can be assumed when both diabetes and certain conditions/complications are listed within a note. (Note: E11.69 requires further specification of complication)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinopathy</td>
<td>E11.319</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>E11.40</td>
</tr>
<tr>
<td>Cataract</td>
<td>E11.36</td>
</tr>
<tr>
<td>Gangrene</td>
<td>E11.52</td>
</tr>
<tr>
<td>Hyperglycemia</td>
<td>E11.65</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>E11.51</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>E11.22</td>
</tr>
<tr>
<td>Gastroparesis</td>
<td>E11.43</td>
</tr>
</tbody>
</table>
To LINK or not to LINK!!
Clinical Justification for HLD and HTN

Linking Language Required

- **DM w/ Hypertension (E11.59)**
- **DM w/ Hyperlipidemia (E11.69)**
  - Further language is needed to link them because the codes have “NEC” in the description and are not assumed
- Any diabetic complication code that has “NEC” in the description
  - These end in an 8 or 9 (ex: E11.29 DM w/ renal complication NEC)
  - Further documentation is needed to specify what the complication is
- “Uncontrolled” DM
  - Needs to be further stated as hyperglycemic or hypoglycemic

Assumed Connection

- CKD**
- Neuropathy (poly, mono, auto)
- Retinopathy
- Nephropathy
- Cataract
- Foot Ulcers**
- PVD
- Dermatitis
- Gastroparesis
- Gangrene
- Hyperglycemia

** - Means a second code is still required to state the severity of the complication
Understanding M.E.A.T.

Documentation of the medical visit must indicate how the physicians are Monitoring, Evaluating, Assessing, or Treating the patient’s chronic conditions.

<table>
<thead>
<tr>
<th>MONITOR</th>
<th>EVALUATE</th>
<th>ASSESS</th>
<th>TREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Progression/Regression</td>
<td>Physical exam</td>
<td>Address or Discuss: Physical exam or test results</td>
<td>Order/Cont. Medications</td>
</tr>
<tr>
<td>Signs/Symptoms</td>
<td>Test/imaging reports</td>
<td>Condition status check</td>
<td>Ordering Therapies</td>
</tr>
<tr>
<td>Ordering labs/imaging</td>
<td>Medications</td>
<td>Counselling</td>
<td>Plan for management</td>
</tr>
<tr>
<td>Referencing labs/other tests</td>
<td>Treatment response</td>
<td>Reviewing records</td>
<td>Referral to specialist</td>
</tr>
</tbody>
</table>

Chronic HF - stable; continue furosemide

Type 2 DM - poorly controlled; HbA1c recently high at 9.5

Type 2 DM w/peripheral neuropathy - decreased sensation BLE monofilament test

COPD - worsening s/s, will check PFTs, add steroid inhaler

Documentation should always support the diagnosis coding with accuracy, specificity and consistency.
Diagnosis Documentation Best Practices | A Call to Action!

1. **Engage** your clinicians and teams; **share why** this matters!

2. **View the Daily Huddle**, preferably at the point of care.

3. **Take action** on each Diagnosis Suggestion.
   - **Document** (remember M.E.A.T.) & Code
   - **Schedule** a Follow-Up Visit (for conditions you do not have time to address)

4. **Monitor your data**; follow your practice and PCP trends.