Hometown Health

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Payments to Medicare Advantage (MA) organizations, like Hometown Health, are risk-adjusted on the basis of diagnosis codes submitted on claims. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses. In addition, the Office of Inspector General (OIG) has shown that some diagnoses are more at risk than others to be unsupported by medical record documentation.

To ensure the complete and accurate depiction of our patient populations overall health status we have developed this educational guide. This guide focuses on diagnosis codes deemed high risk by the CMS and OIG.

Major Depressive Disorder (MDD)

According to the DSM-5™, major depressive disorder is characterized by discrete episodes of at least 2 weeks' duration involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions. A diagnosis based on a single episode is possible, although the disorder is a recurrent one in the majority of cases.

**It is important to remember that 'Bereavement' or 'Grief' may induce great suffering, but it does not typically induce an episode of major depressive disorder.*

MDD specification requires 2 components:

1. **Episode**
    - **Single** – First episode of initial diagnosis
    - **Recurrent** – Any subsequent episode following the initial single episode
2. **Severity**
    - **Mild** – (PHQ-9 score 5-9) Few, if any, symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social and occupational functioning.
    - **Moderate** – (PHQ-9 score 10-19) The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe".
    - **Severe** – (PHQ-9 score 20-27) The number of symptoms is substantial in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.
        - Severe is further classified by **with or without psychotic features**
    - **In partial remission** – Less than 2 months without significant symptoms (some symptoms may still be present during this time, but full MDD criteria is not met)
    - **In full remission** – Greater than 2 months of no symptoms

	Mild	Moderate	Severe without psychotic features	Severe with psychotic features	In Partial Remission	In Full remission
Single Episode	F32.0	F32.1	F32.2	F32.3	F32.4	F32.5
Recurrent	F33.0	F33.1	F33.2	F33.3	F33.41	F33.42

Cancer

It is appropriate to code cancer as active during the timeframe between the initial diagnosis and the completion of treatment (either by excision; or by completion of chemotherapy and/or radiation therapy). Untreated cancer that is being monitored (watchful waiting) should be coded as active.

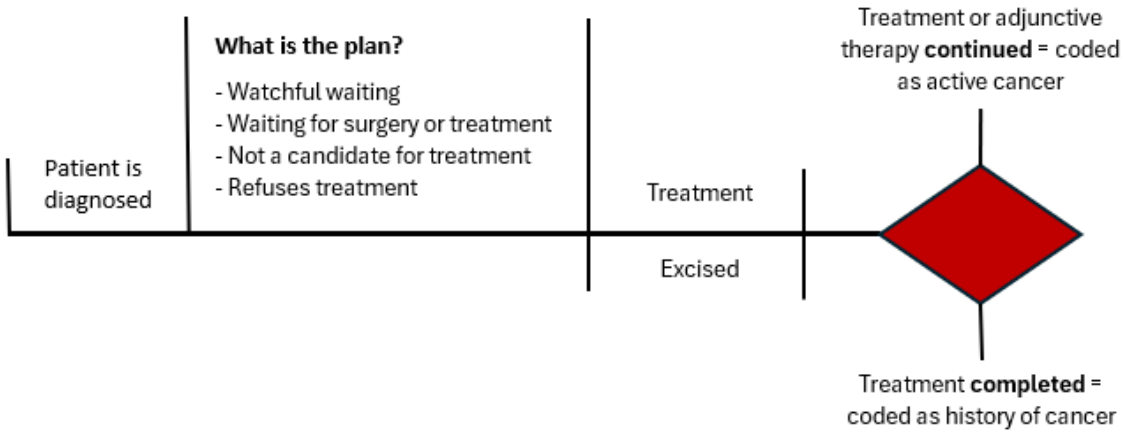
After completion of treatment, it is appropriate to use a 'history of malignant neoplasm' code *[Z85.-]*

**It is important to remember that the use of quantifying language such as, "Rule out, probable, possible or consistent with" cannot be coded as active cancer in the office setting.*

The following ICD 10 CM coding guidelines will be helpful in deciding which codes are appropriate:

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
- When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.
- Follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists.
    - Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.
        - Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
        - Z85.- Personal history of malignant neoplasm
- Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code.
- ****Leukemia is the only exception, as this condition has specified 'in-remission' codes***

Current vs History of Malignancy



Peripheral Vascular Disease (PVD)

Treatment of PAD/PVD should include documentation of mediations such as statin therapy, aspirin or clopidogrel for both asymptomatic and symptomatic patients.

Obtain an ABI or equivalent device (wave form doppler) for patients who screen positive and for asymptomatic patients age 65 and older, or age 50 with a history of smoking, diabetes and other high-risk comorbid conditions.

Interpreting the Ankle-Brachial Index (ABI)[2]

ABI	Perfusion Status
≥ 0.90	Peripheral Artery Disease
0.91 to 0.99	Borderline
1.00 to 1.40	Normal
> 1.40	Concern for noncompressible arteries, association with Diabetes Mellitus

Documentation should include the following specifications/classifications:

- System: Arterial or Venous
- Vessel type : Native or graft (autologous, nonautologous biologic, nonautologous nonbiologic)
- Presence: include if there is an ulceration and/or gangrene
- Anatomic location: include site, laterality
- Complicating factors: intermittent claudication, rest pain, ulceration, and gangrene

Stroke / Cerebral Vascular Accident

Acute CVA/stroke *[I63.-]* should only be coded during the acute phase. After the initial encounter for treatment, if no residual effects are present, the CVA/stroke should be coded as 'History of CVA' (Z86.73).

After the initial encounter, any residual effects (hemiplegia/monoplegia, speech or cognitive symptoms) should be coded as a late effect (sequelae) of cerebral infarction *[I69.3-]*

STROKE SEQUELAE

M (Monitoring)	Decreased grip strength, numbness or tingling, gait disturbances
E (Evaluating)	Length of time residual condition has been present (e.g. date of stroke)
A (Assessing / Addressing)	Status of residual condition: resolving, stable, progressing
T (Treating)	Continue PT/OT, use of walker or wheelchair

Acute Myocardial Infarction (MI)

Myocardial infarctions have a special coding rule that allows for an MI to be coded as acute *[I21.xx]* for the four weeks (28 days) following the initial encounter for treatment. This four week timeframe includes the initial encounter, transfer to another acute facility, transfer to post-acute setting, and any PCP follow up visits following discharge.

If a patient is still receiving care related to MI after the 4-week timeframe, it would be appropriate to assign an aftercare code *[Z51.89].*

For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, should be assigned.