Diagnosis Coding: Building the Case for Excellent Outcomes

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Aledade

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

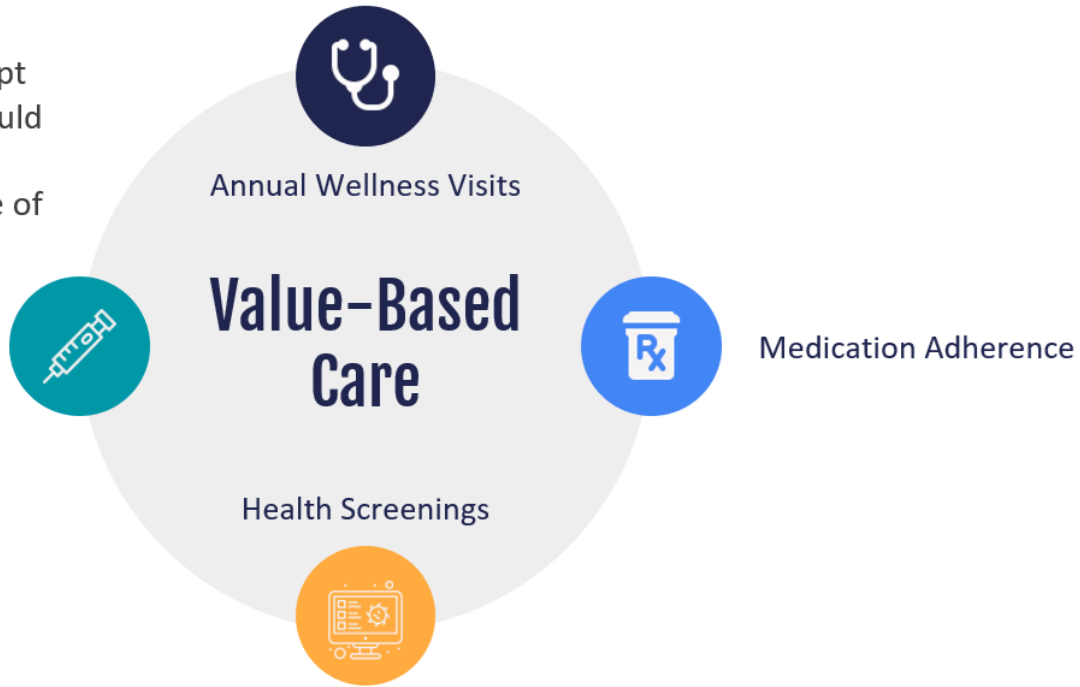
Juggling declining reimbursement and minimal influence on payment

Workforce Shortages

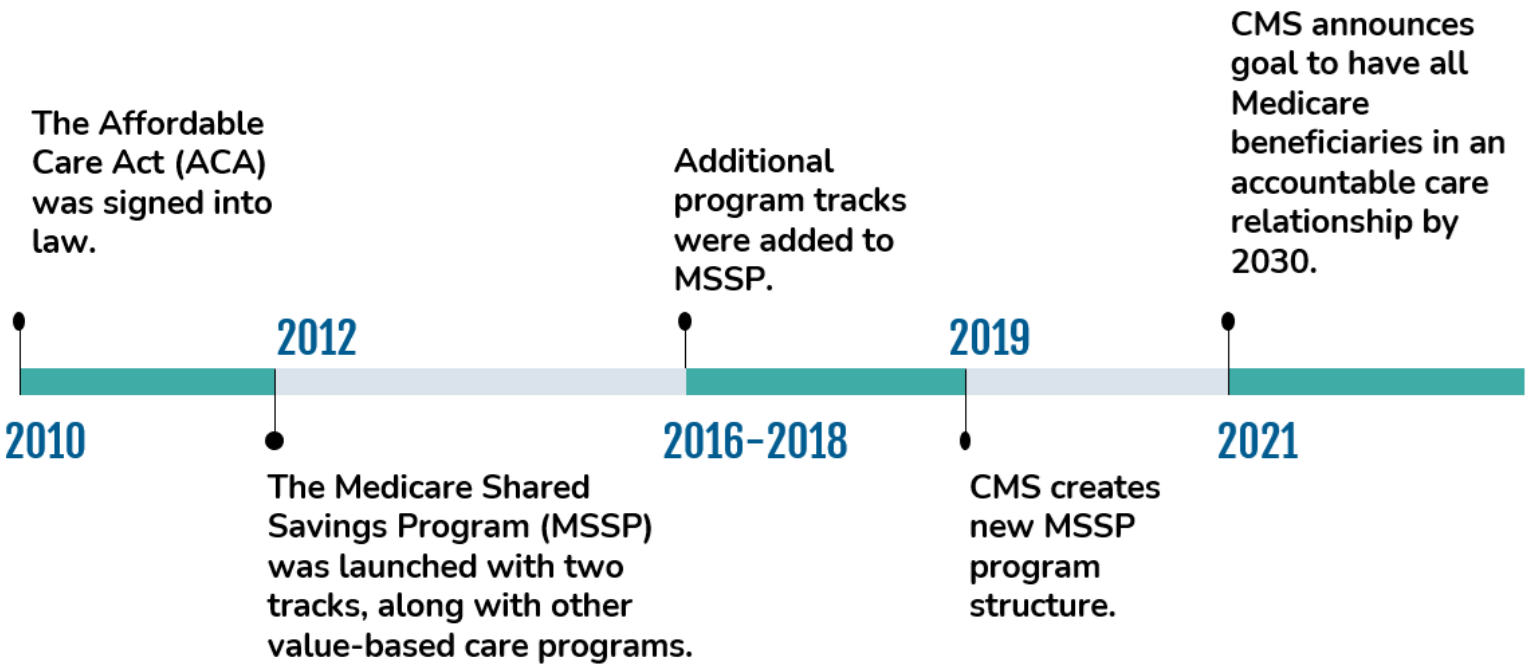
Struggling to fill open positions and retain qualified staff

What is value-based care?

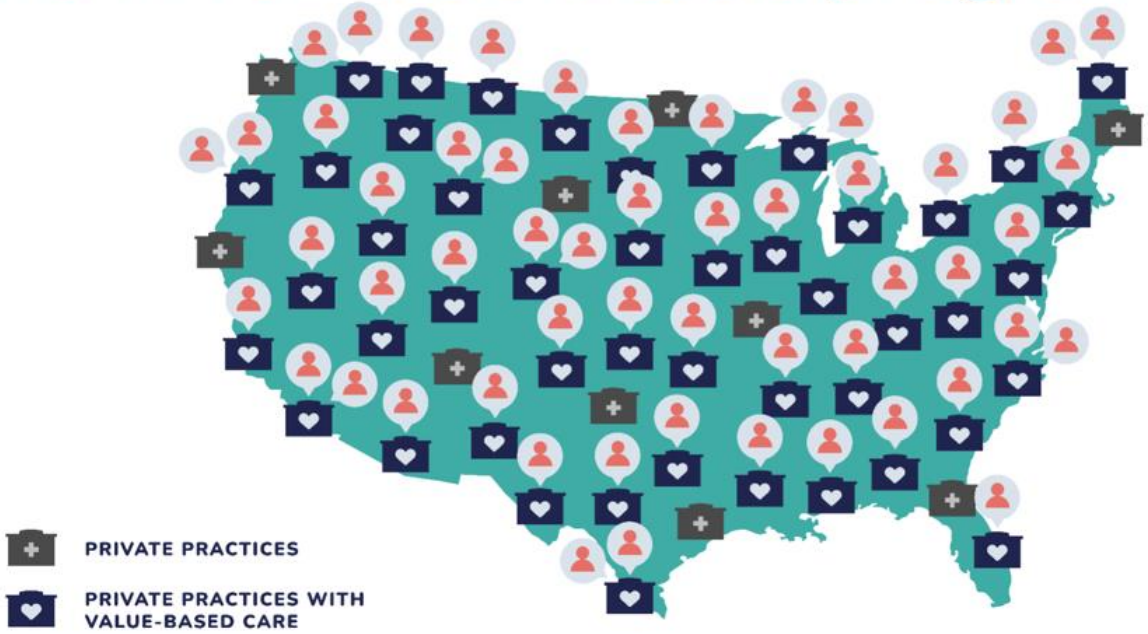
Value-based care is the concept that health care physicians should be paid for keeping people healthy rather than the volume of services delivered.



The history of value-based care.

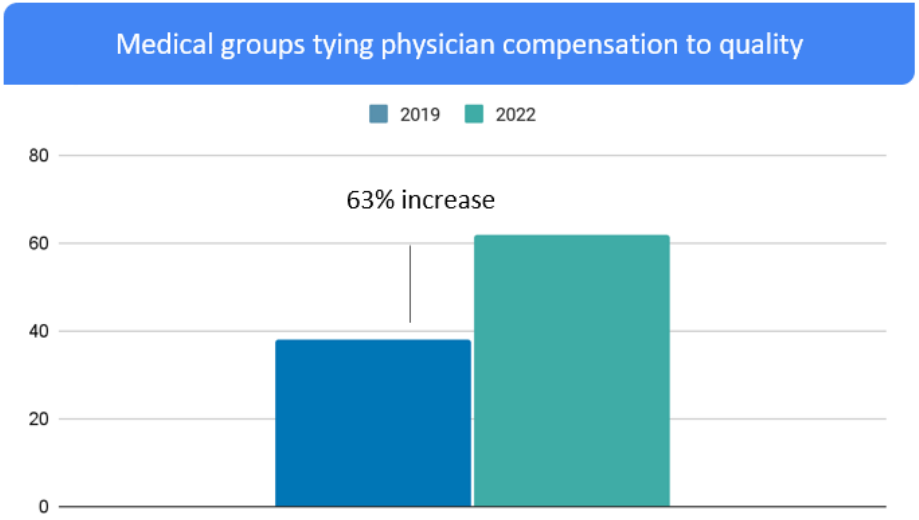


Because of MSSP success, by 2030, every Medicare beneficiary should be cared for by a physician in a value-based program.



Physician compensation is increasingly tied to quality outcomes.

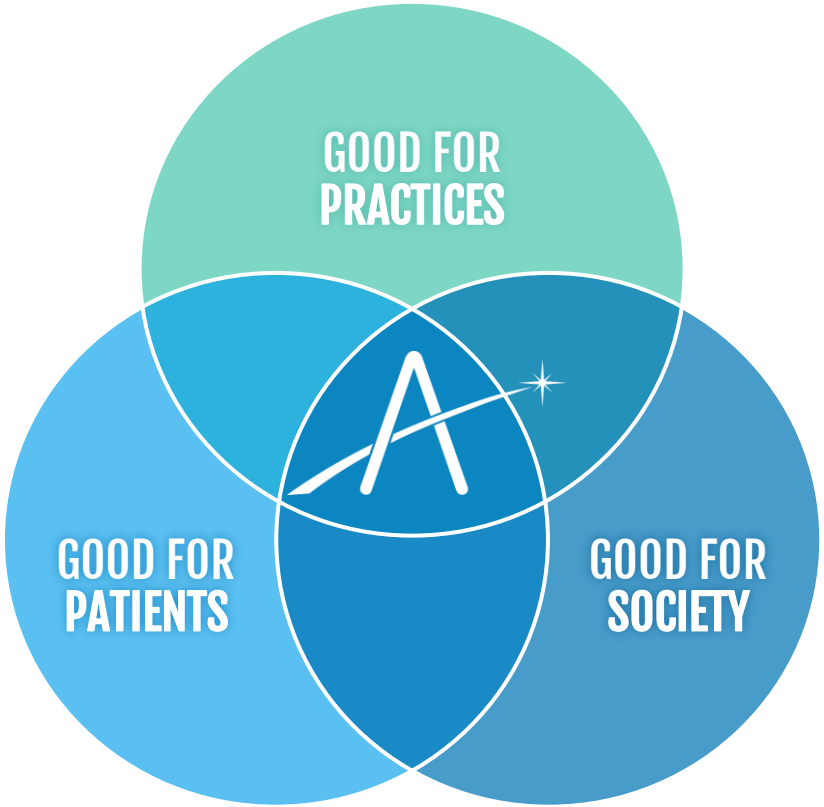
The COVID-19 pandemic has accelerated the share of physician compensation tied to quality performance.



Source: 2022 MGMA DataDive Provider Compensation

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

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**

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

Monitoring ⇔ **Evaluation** ⇔ **Assessment** ⇔ **Treatment**

What are we really talking about?

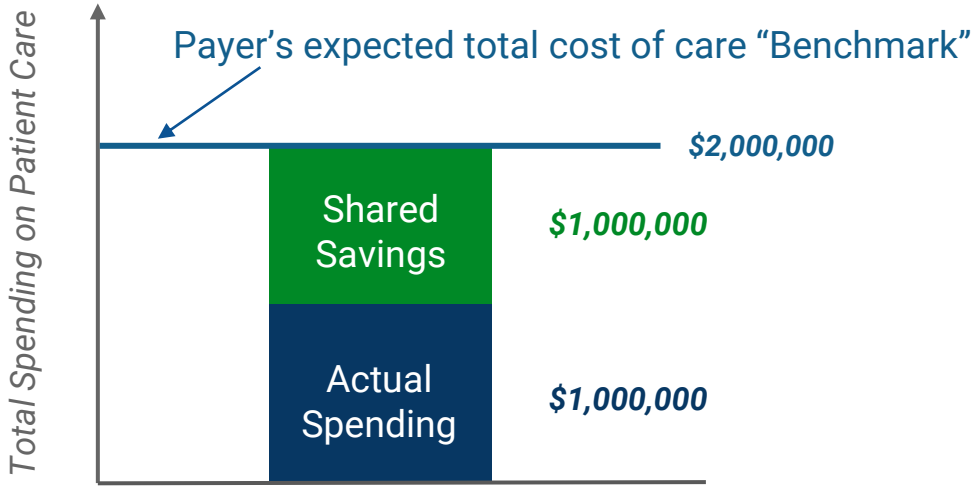
Risk Stratification: alignment of the **right patients for the right clinical initiatives**, according to their clinical diagnoses and burden of illness.

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 may educate providers about risk adjustment principles. Aledade does not incentivize coding of weighted diagnoses, nor push practices to uncover diagnoses for the purposes of risk inflation.

Calculating the Benchmark: a tale of two women

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.

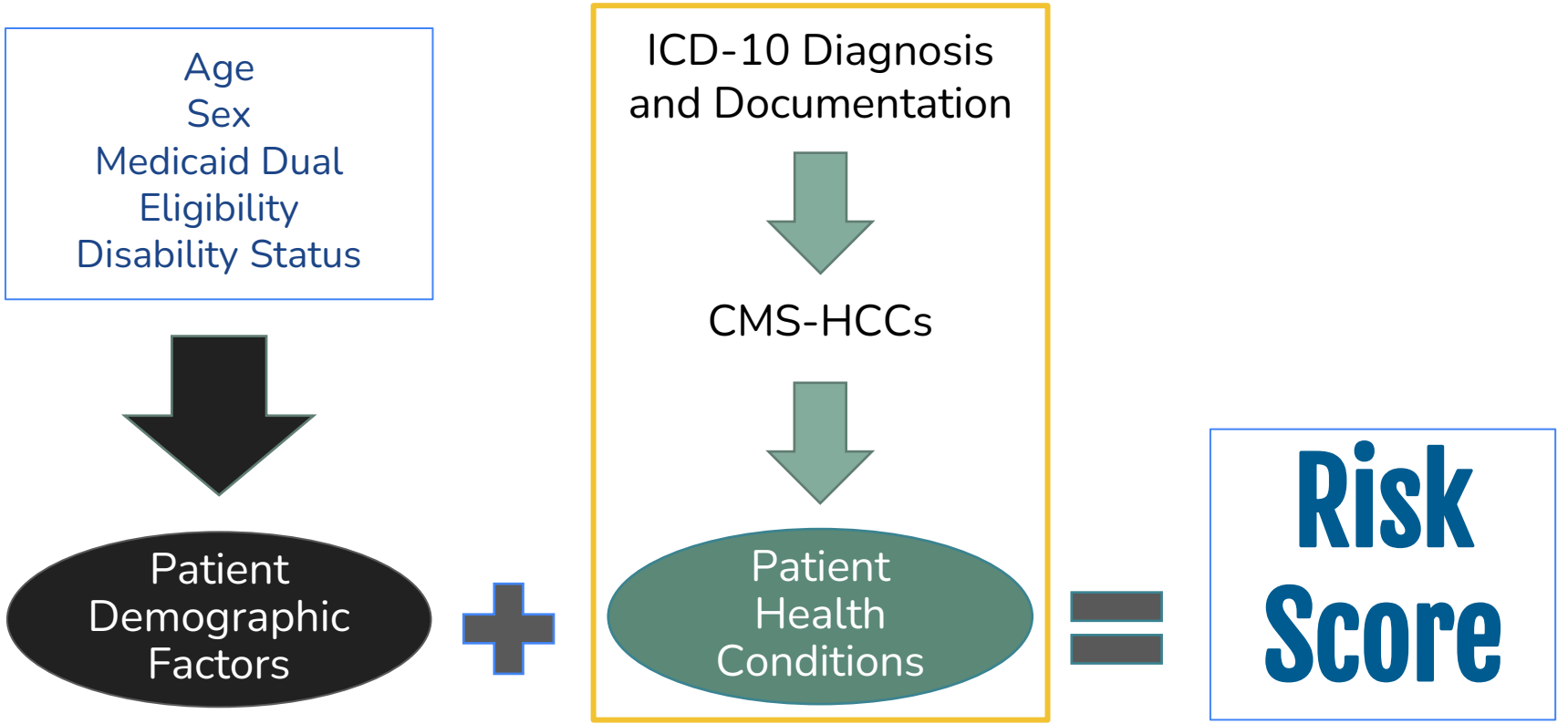
Ms. V. is a 76-year-old retired teacher.

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.



What is the impact of Accurate and Complete Diagnosis Coding?

Ms. W: All Conditions Documented	
76 year-old female	0.468
Familial Hyper-cholesterolemia	-
History of Breast Cancer	-
Patient Total RAF	0.468
Yearly Reserve for Care	$4,680

Ms. V: No Conditions Documented (Demographics Only)	
76 year-old female	0.468
Medicaid eligible	0.177
DM not coded	-
Vascular Disease not coded	-
CHF not coded	-
No interaction	-
Patient Total RAF	0.645
Yearly Reserve for Care	~~$6,450~~

Ms. V: Some Conditions Documented	
76 year-old female	0.468
Medicaid eligible	0.177
DM (no complications)	0.104
Vascular Disease without complication	0.298
CHF not coded	-
No interaction	-
Patient Total RAF	1.047
Yearly Reserve for Care	$10,470

Ms. V: All Conditions Documented	
76 year-old female	0.468
Medicaid eligible	0.177
DM with Vascular Manifestations	0.318
Vascular Disease with complication	0.400
CHF coded	0.323
+ disease interaction bonus RAF (DM + CHF)	0.182
Patient Total RAF	1.868
Yearly Reserve for Care	~~$18,680~~

Difference of **>$12,000** in Yearly Reserve for

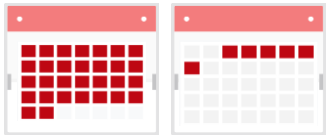
What can incomplete coding mean for health care savings?

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** days[3] 

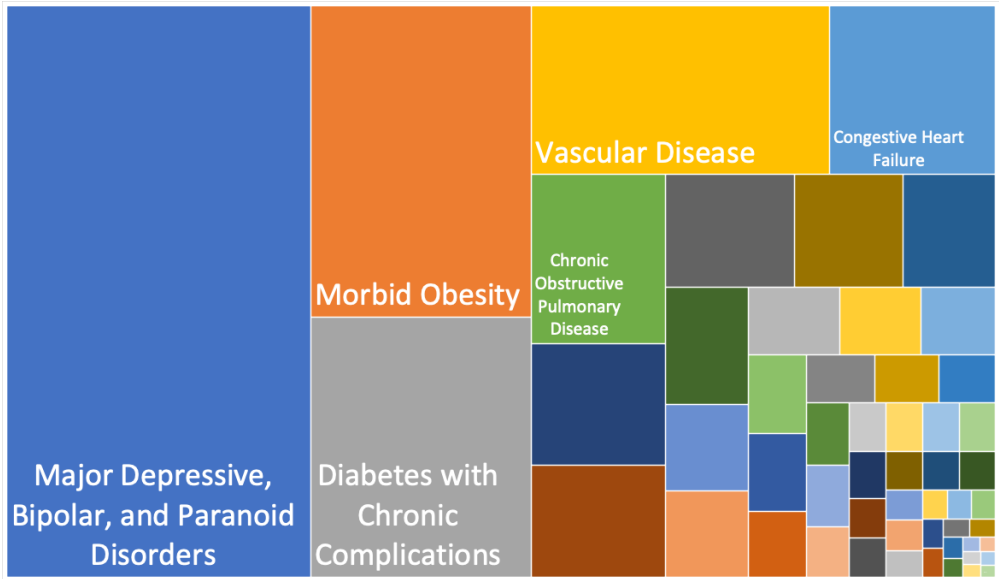
[1] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb204-Most-Expensive-Hospital-Conditions.jsp
[2] https://www.beckershospitalreview.com/eds/cost-of-er-visits-increased-31-between-2012-16-5-findings.html
[3] https://aspe.hhs.gov/basic-report/post-acute-and-long-term-care-primer-services-expenditures-and-payment-methods

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 lanuage

- 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 O2)
- Bronchitis - Acute or Chronic
- Emphysema
- Asthma (Commercial Payers)

Diabetes

Depression

Diet (Obesity)

Dyspnea

Drugs (+Alcohol)

Dementia

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)

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

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.

There is never a need to "upcode"

Just be precise

Diagnosis and monitoring: PHQ-9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the news, watching TV	0	1	2	3
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	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
				PHQ-9 total score:	

PHQ-9 Score	Diagnosis
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)

Retinopathy	**E11.319**
Neuropathy	**E11.40**
Cataract	**E11.36**
Gangrene	**E11.52**
Hyperglycemia	**E11.65**
Peripheral Vascular Disease	**E11.51**
Chronic Kidney Disease	**E11.22**
Gastroparesis	**E11.43**

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 **M**onitoring, **E**valuating, **A**ssessing, **or** **T**reating the patient's chronic conditions.

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