

# Maximizing Revenue through Correct Diagnosis Coding

Jaci Kipreos CPC CPMA  
CEMC COC CPCI

President and Owner  
Practice Integrity, LLC

[jaci@practiceintegrity.com](mailto:jaci@practiceintegrity.com)

# About the Presenter

## **Jaci J Kipreos CPC, COC CPMA, CPC-I, CEMC**

Jaci has been working in the field of medical coding and auditing for over 30 years and has been a Certified Professional Coder (CPC) since 1994 and attained her COC for facility based coding issues in 2005. She has also obtained her credential as a Certified Professional Medical Auditor and is certified in the specialty of Evaluation and Management Coding.

Kipreos has worked in a variety of practice settings and has particular expertise in coding for family practice, urgent care, OB/GYN, general surgery, Medicare's Teaching Physician Guidelines, with a particular emphasis on compliance with Evaluation and Management guidelines.

# Disclaimer

- Information contained in this text is based on CPT®, ICD-10-CM and HCPCS rules and regulations. However, application of the information in this text does not guarantee claims payment. Payers' interpretation may vary from those found in this text. Please note that the law, applicable regulations, payer' instructions, interpretations, enforcement, etc., may change at any time. Therefore, it is crucial to stay current with all local and national regulations and policies.

# Learning Objectives

Explain the correlation of medical decision making and diagnosis coding

Identify coding rules for professional fee coding vs facility coding vs risk adjustment

Describe how to find the guidelines for use of ICD-10 codes and understand key regulations

## Why are we here?

---

Diagnostic codes are an important and sometimes misunderstood aspect of correct coding. They are a key element in all claims that support medical necessity and reflect severity.

---

Improper ICD-10 diagnostic coding can lead to claim denials and other missed revenue opportunities. It can also make the practice a target for audits and expose it to risk.

# What is Diagnosis Coding?

3 to 7 character code (ICD10-CM) (Clinical Modifications) that can;

- Track the health history of a patient
- Explain medical necessity
- Explain medical complexity
- Explain medical risk
- Provide important data elements for population health
- CDI link
- HCC/Risk

# What is Diagnosis Coding?

A diagnosis code will finish the story of the patient encounter

CPT= what was done

ICD10 CM = Why was it done

So what about  
payment? I  
know you are  
thinking RVUs

- Denials due to lack of medical necessity
- Denials due to use of unspecified codes
- Defend or support high level E/M codes
- Inpatient DRG
- Risk adjustment



# Biggest changes in past three years

Elizabeth O'Donnell

Chief Financial Officer/Virginia Cancer Institute

*"We are looking at diagnosis coding differently. We have gone for coding the problem defining the visit to coding the complete patient. This is difficult for physicians because their expectation is that if they aren't treating a disease, they shouldn't be coding it."*

Colleen Gianatasio, CPC, CPCP, CPMA

Risk Coding Education Specialist /Capital District Physician's Health Plan

*"Diagnosis coding has received increased attention with the shift to value based reimbursement and the nationwide focus on improving health care in the United States."*

Brian Boyce, BSHS, CPC, CPC-I, CRC, CTPRP

CEO /IonHealthcare

*"Diagnosis codes in my opinion have grown in use across many areas in the industry. Beyond their use in risk adjustment HCC models for prospective payments, they are also used heavily in data analytics, and new quality measure initiatives. They have become an important administrative "vital sign" of sorts."*



# Let's Dig In

How does all this work?

# Medical Decision Making and Diagnosis Coding

- Medical decision making and medical necessity
  - Often used interchangeably
  - Medical decision making is the thought process in which a provider determines a diagnosis and treatment
  - Medical decision making is one of the key elements in the selection of a level of evaluation and management service
  - Medical necessity supports the need to provide the service

# Medical Decision Making

- *From the Winter 1991 CPT Assistant Newsletter the following note on Medical Decision Making:*
- “Determine the complexity of the decision making. ...You must determine the complexity of the decision making *separately and distinctly before factoring this into the code selected.*”
- (i.e., determining the type of decision making is a separate process from the selection of a level of E/M service. **First**, you determine the type of decision making; **then** you relate the type of decision making to the other key components before selecting a specific code.)

## What is Medical Necessity - Reimbursement Issues

- **AMA:**
- “Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: in accordance with generally accepted standards of medical practice clinically appropriate in terms of type, frequency, extent, site and duration not primarily for the convenience of the patient, physician or other healthcare provider.”

# What is Medical Necessity - Reimbursement Issues

- **CMS:**
- “...No payment may be made under Part A or Part B for any expenses incurred for items or services which...
- are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

# What is Medical Necessity - Reimbursement Issues

## CMS:

- **CMS Internet Only Manual (IOM) 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 states:** “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The amount of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as possible after it is provided to maintain an accurate medical record.”

# Medical Decision Making and Medical Necessity

How is this conveyed on a CMS 1500 or other claim?

A diagnostic statement or ICD10 code(s) will provide the thought process of the provider as well as provide the need for treatment and the complexity and status of the patient.



# Rules on the Professional Side of Billing and Coding



The guidelines that are used to code and bill point to the importance of diagnosis coding and their link to showing medical necessity.



Lets start with the Medicare Documentation Guidelines for Evaluation and Management Codes (1995 and 1997)

# Professional Guidelines

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - reason for the encounter and relevant history, physical examination (ICD10)
  - findings and prior diagnostic test results; (ICD10)
  - assessment, clinical impression or diagnosis; (ICD10)
  - plan for care; and
  - date and legible identity of the observer.

# Professional Guidelines

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. (MDM) (ICD10)
- Past and present diagnoses should be accessible to the treating and/or consulting physician. (ICD10)
- Appropriate *health risk factors* should be identified. (MDM) (ICD10)

# Professional Guidelines

- **The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented. (MDM) (ICD10)**
- **The CPT and ICD-10-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.**

# Professional Guidelines – CPT Example

## Subsequent Hospital Visit

- 99231 – Typically patient is *stable, recovering or improving* (approximately 15 minutes)
- 99232 – Typically the patient is *responding inadequately to therapy* or has *developed a minor complication* (25 minutes)
- 99233 – Typically the patient is *unstable* or has *developed a significant complication* or *significant new problem* (35 minutes)

## Guidance for facility payments

- **DRG** – “Prospective payment rates based on Diagnosis Related Groups (DRGs) have been established as the basis of Medicare’s hospital reimbursement system. The DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital.”

[www.cms.gov](http://www.cms.gov).

- PDX/Primary procedures
- MCC – Major complications and comorbid conditions
- CC – Complications and comorbid conditions

## Guidance for facility payments

- The concept of case mix complexity initially appears very straightforward. However, clinicians, administrators and regulators have often attached different meanings to the concept of case mix complexity depending on their backgrounds and purposes
  - Severity of illness. Refers to the relative levels of loss of function and mortality that may be experienced by patients with a particular disease.
  - Prognosis. Refers to the probable outcome of an illness including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence and the probable life span.
  - Treatment difficulty. Refers to the patient management problems which a particular illness presents to the health care provider. Such management problems are associated with illnesses without a clear pattern of symptoms, illnesses requiring sophisticated and technically difficult procedures and illnesses requiring close monitoring and supervision.

## Guidance for facility payment

- Case Mix continued...
  - Need for intervention. Relates to the consequences in terms of severity of illness that lack of immediate or continuing care would produce.
  - Resource intensity. Refers to the relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular illness.
- The provider is ultimately responsible for this information whether you are billing for the facility or not.

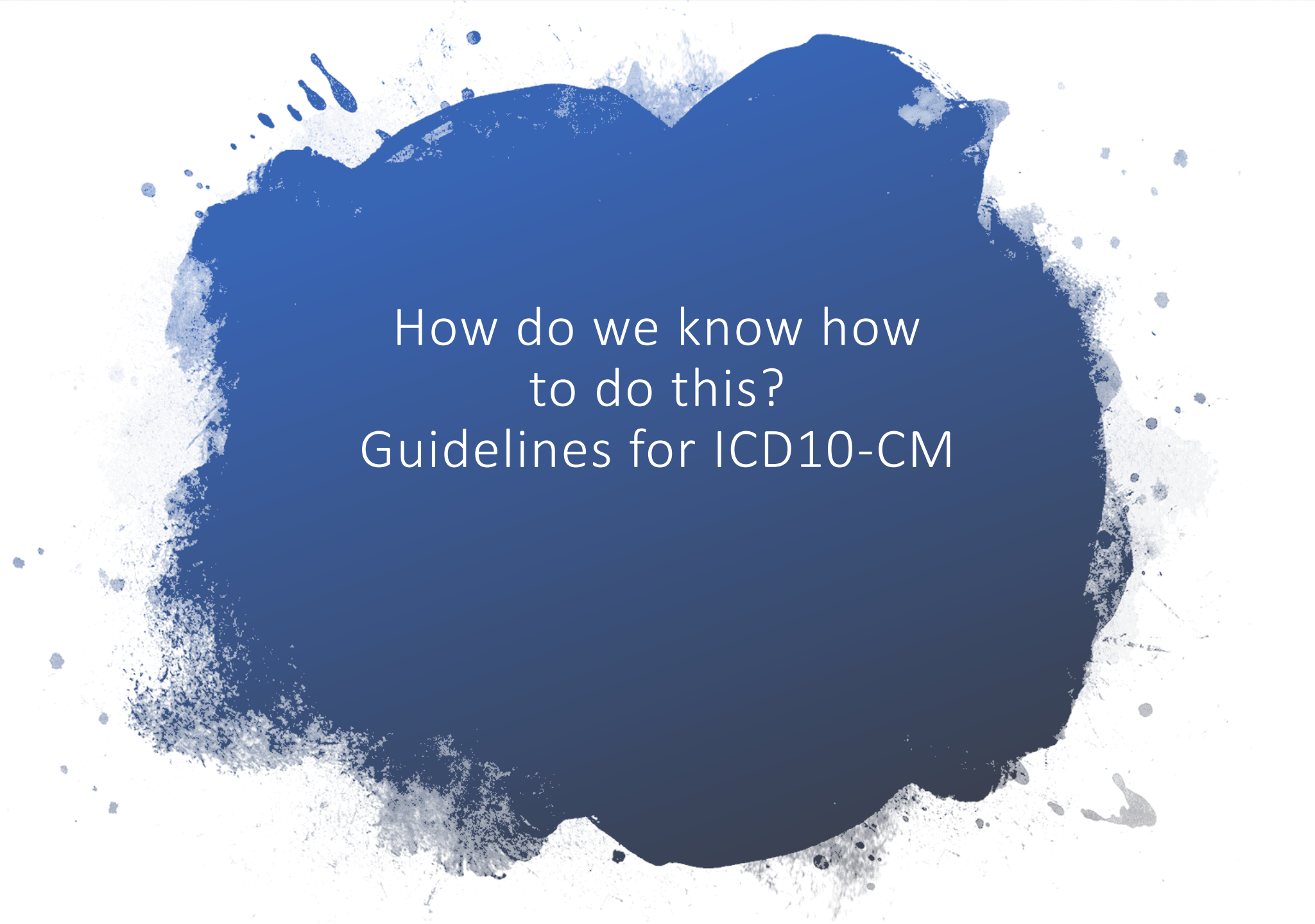


# Guidance for Risk Adjustment

- Medicare risk adjustment varies reimbursement for Medicare Advantage or managed care enrollees' health expenditures according to the severity of the individual patient's illness. Payments are higher for less-healthy members (for example, those who are more expensive to treat) and lower for healthier members. Providers are reimbursed based on the difference between the calculated payment and the actual cost of patient care; they are incentivized to document and code all of a patient's diseases, and to manage resources carefully.

# Guidance for Risk Adjustment

- Diagnosis codes are categorized into disease groups to include conditions that are clinically related, with similar cost implications. Payments are based on the most severe manifestation of disease, when less severe manifestations also are present.
- Risk adjustment is now used across all facets of healthcare. For example, Medicaid and commercial plans are using risk adjustment models to assist in predicting patients' future needs,



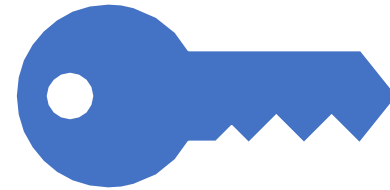
How do we know how  
to do this?  
Guidelines for ICD10-CM

# The Official Guidelines for Diagnosis Coding

- Found in the ICD10-CM code book
  - Guidelines in book will reflect prior year guidelines
- Guidelines can be downloaded at
- <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf>
- or just Google...



Let's Review Some



Key Guidelines

# General Guidelines

Explains how to use  
the book

Helps to understand  
the format and the  
structure

Meaning of the  
symbols

How to read the book

- What do the instructions found along with the codes really mean?

How to use the index

# General Guidelines



## Section II. Selection of Principal Diagnosis



The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

# General Guidance

## **Code all documented conditions that coexist**

- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.
- Do not code conditions that were previously treated and no longer exist.
- However, history codes (categories Z80- Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.



## Guidelines that matter - Hypertension

- The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index.
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

# Hypertension example

- Hypertension – I10
- Hypertension with HF – I11.0
- Hypertension with CKD – I12.0, I12.9

## Guidelines that matter – Diabetes

- As many codes within a particular category as are necessary to describe all of the complications of the disease may be used.
- If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.
- An additional code should be assigned from category Z79 to identify the long-term (current) use of insulin or oral hypoglycemic drugs. (not needed for type 1)

# Guidelines that matter – Risk factors

Remember-  
code all  
conditions  
that co-  
exist...

---

Obesity – E66.0 –  
E66.9

---

Smoking - current,  
history of, dependence

---

Non-compliance –  
Z91.11 – Z91.19

---

# Payment issues

---

What does the first listed diagnosis on the claim say about the complexity of the encounter?

---

Does the diagnosis make a statement about how hard the provider had to work? This applies to any place of service, any setting.

# What does the claim say?

---

Hypertension with CKD stage 5 in a patient who is a smoker vs Hypertension

---

Diabetes type 2 controlled with insulin in a patient who is obese and smoker on antidepressants vs DM.

---

Patient with hypertension who has been non-compliant with medications and now requires hospital admission

# Risk Adjustment Payment Pitfalls

**John Doe, DOB 05/21/1941, Date of Encounter 2/5/2019**

Subjective: 71 YO male patient complains of mild **shortness of breath on exertion**. This has been happening for years with no chest pain. Pt has **type 2 diabetes** with normal blood sugars readings at home and suffers from **peripheral arterial disease (PAD) related to his diabetes**. He **uses oxygen to help his breathing**.

Objective: BP 130/85 Wt. 160lbs P: 75 Temp 98.8 O2 Saturation 87% on Room air. Improved to 95% with 2 liters of oxygen - PE exam is normal Lungs: Clear with no wheezing, Heart S1 S2 heard no murmur, No edema

Diagnostic test: Echo shows stable pulmonary artery pressure of 45 mmHg (normal 25)  
Prior chest X-ray revealed **Calcified thoracic aorta** with tortuosity with clear lung fields, HgA1c was 6.5 with normal cholesterol

# Risk Adjustment Payment Pitfalls

## • Diagnosis Codes

Type 2 Diabetes E11.9

PAD – I73.9

Shortness of Breath – R06.02

## • HCC Part C/Weight

HCC 19 / 0.104

HCC 108 / 0.298

0

HCC total = 0.402



# Risk Adjustment Payment Pitfalls

## • Diagnosis Code

Type 2 Diabetes with PAD E11.51  
Atherosclerosis of the Aorta – I70.0  
Pulmonary Hypertension – I27.2  
Chronic Resp Failure with hypoxia –  
J96.12

## • HCC Part C/Weight

- HCC 18 / 0.318
- HCC 108 / 0.298
- HCC 85 / 0.323
- HCC 84 / 0.302

HCC Total = 1.241

# What's Next? Next 5 Years

Elizabeth O'Donnell

Chief Financial Officer/Virginia Cancer Institute

*"A complete diagnostic view of the patient will influence reimbursement in much the same way RVUs did."*

Rhonda Buckholtz, **CPC, CPCI, CPMA, CDEO, CRC,**  
Chief Compliance Officer /Century Vision Global

*"As we move towards population management in healthcare and advanced payment models the patients clinical condition will have greater impact than we have now."*

Colleen Gianatasio, **CPC, CPCP, CPMA**

Risk Coding Education Specialist /Capital District Physician's Health Plan

*"I anticipate that we will see a continuing trend of aligning risk adjustment across lines of business with the various quality programs like HEDIS and Medicare Stars. I anticipate the trend of focusing on social determinants of health and their impact on population health to continue."*

# Down the road...maybe in the not too distant future...

---



- ICD11 –CM



# Thank you!

Jaci Kipreos  
[jaci@practiceintegrity.com](mailto:jaci@practiceintegrity.com)  
Practice Integrity  
(804)467-1554