The Top Conditions Series
Autoimmune Disorders
Documentation & Coding

Commercial Risk Adjustment Operations

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- **The following is intended to be an informational resource only. Nothing expressed in this presentation should be construed as medical advice.**

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“Education is the most powerful weapon you can use to change the world.”

- Nelson Mandela

By reviewing this presentation, you will learn:

- Objective and Intent
- Best Practices - Documentation
- ICD-10-CM Quick Tips
- Coding Example Review
- Continued Educational Resources

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Objectives and Intent

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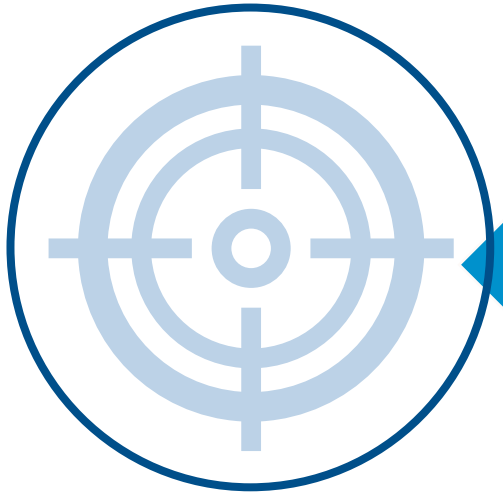
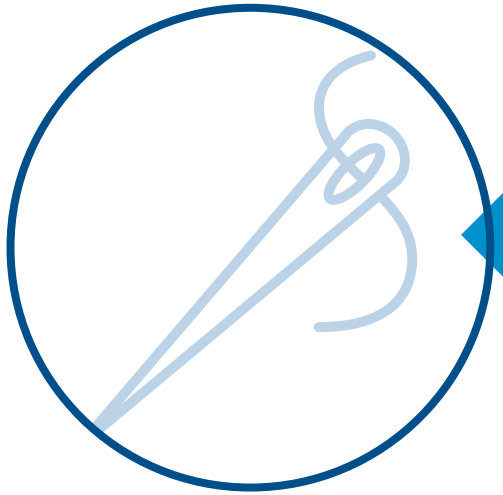
The Top 10 Series | Objective and Intent



Enhance the accuracy and completeness of provider documentation, claims medical diagnosis coding, and promote proper reimbursement.



Instill providers with the knowledge, tools, and resources to accurately assess, treat, document, and code the current health status of Florida Blue's members.

Accurate coding ensures the Centers for Medicare and Medicaid (CMS) is fairly and accurately measuring the health of the Affordable Care Act (ACA) population as part of the ACA Risk Adjustment Program.

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Best Practices - Documentation

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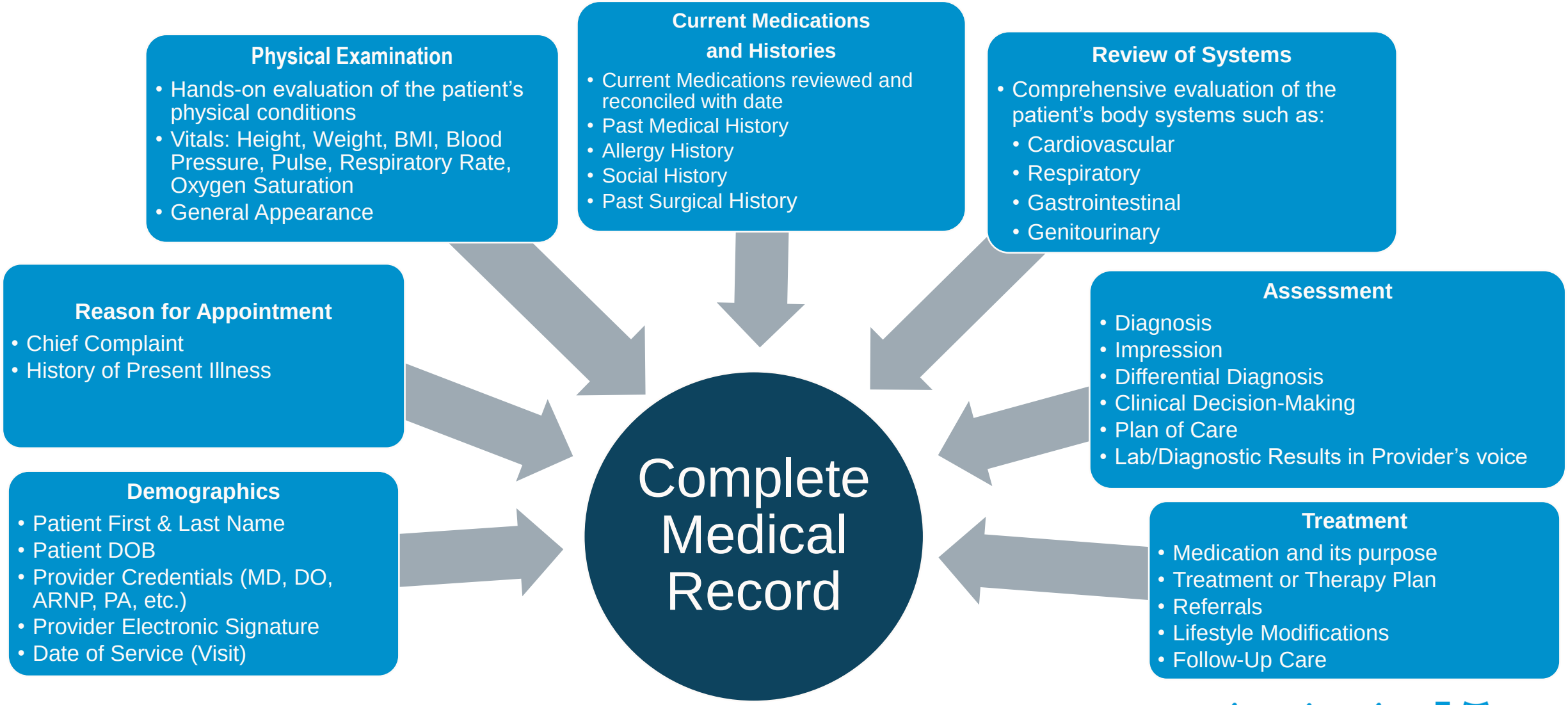
Critical Elements of Medical Record Documentation



Note: This is a partial list.

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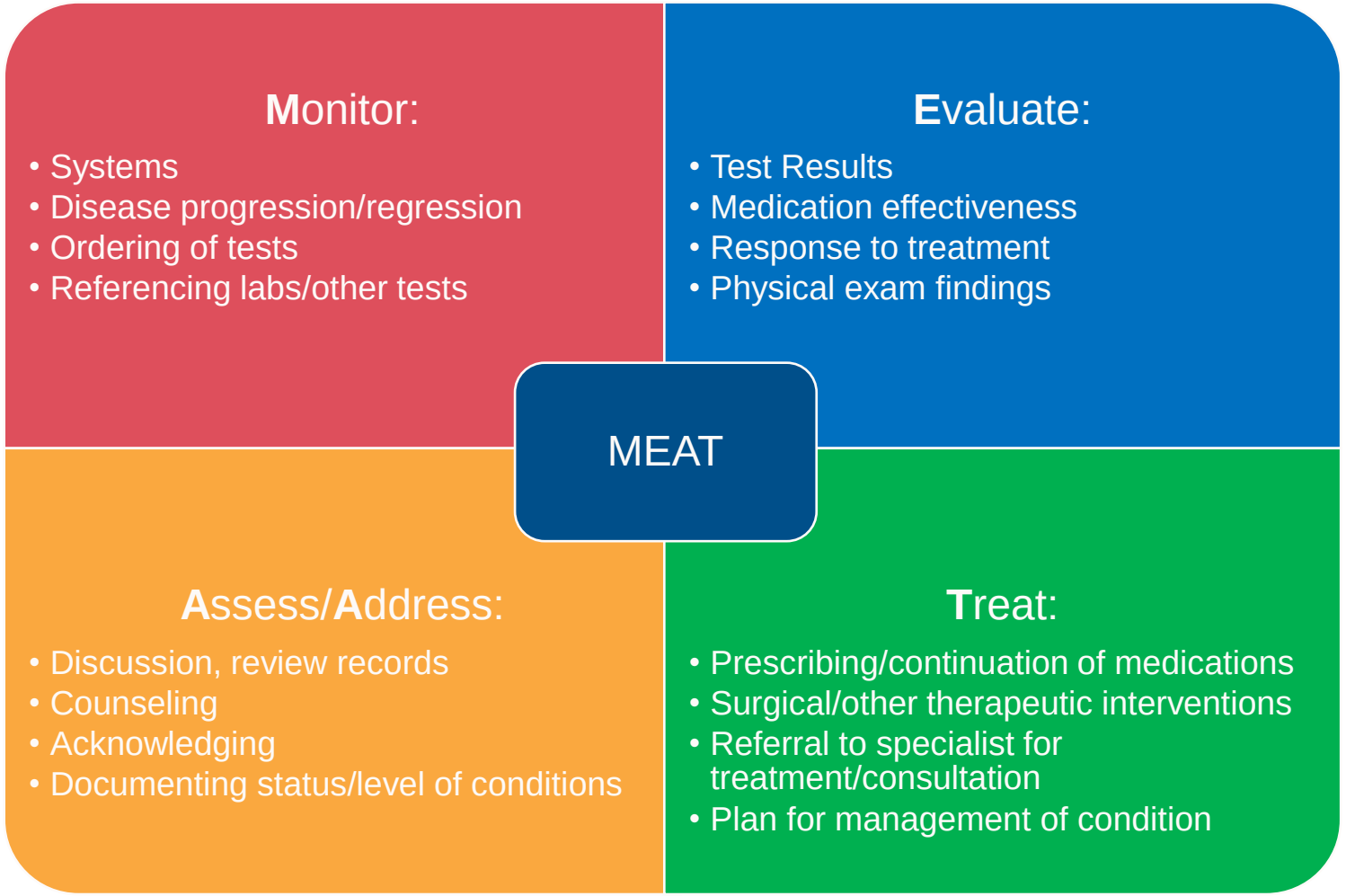
Best Practices - Documentation

- Accurate, complete **MEAT** documentation of chronic condition diagnoses by clinicians is an essential component of the risk adjustment and HCC process. Most chronic conditions match to an HCC.
- To support a Hierarchical Condition Category (HCC), documentation must support the presence of the disease/condition. Additionally, it must include the clinical provider's assessment and/or plan for management of the disease/condition.
- Most organizations use the *M.E.A.T*. criteria – **Monitoring**, **Evaluation**, **Assessment, and Treatment** for their documentation practices. As well as ICD-10-CM diagnosis coding and HCC assignments.

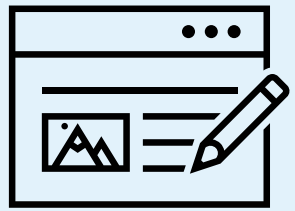


Helpful Tips

Best Practices - Documentation

Current Conditions

- Code chronic conditions on an annual basis, at least.
- Code all existing conditions as many times as patient receives care and treatment.
- **Do not code** for conditions previously treated and no longer exist (history of).
- Document whether the condition is being treated by a specialist, include the diagnosis code description/condition and status. E*xample*: Patient on Coumadin for atrial fibrillation, followed by Dr. Hill.



Specificity

- ICD-10 code selection should be at the highest level of specificity.
- Include chronic or acute, site, laterality, severity, status, etc., in medical record.
- Be sure diagnosis codes billed are consistent with medical record documentation. ICD-10 code should be followed by a written-out description.
- Example: I10, Essential Hypertension.

Unconfirmed Diagnosis

- **Do not code** unconfirmed diagnoses such as probable, possible, suspected, working diagnosis.

ICD10-CM Guidelines

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Best Practices for Documentation of Autoimmune Disorders: Rheumatoid Arthritis

Subjective

In the **Subjective** section of the office note, document any current symptoms of the autoimmune disorder reported by the patient (joint pain, swelling or stiffness, fatigue, episodes of fever, etc.)

Objective

The **Objective** section should include:

- Current associated physical exam findings such as joint destruction and deformities
- Laboratory findings such as CRP, ESR, rheumatoid factor, anti-CCP, etc.
- Imaging results such as MRIs and x-rays

Assessment

In the **Assessment** section, describe the following:

- The final rheumatoid arthritis diagnosis to the highest level of specificity (e.g., seropositive, seronegative)
- The joints affected, laterality, status (active vs. remission).
- Clearly link associated conditions or manifestations of rheumatoid arthritis by using linking terms such as “due to” or “secondary to”
- Include the status (stable, improved, etc.)
- Document details of any organ involvement

Plan

In the **Plan** section of the office note, document a specific and concise treatment plan, for example:

- Referral to rheumatologist
- Laboratory tests and diagnostic imaging orders
- Patient education, including self-management
- Clear link between the rheumatoid arthritis diagnosis and all medications being used to treat the condition

Coding Basics: Autoimmune Disorders-Rheumatoid Arthritis

Seropositive (Category M05)

- In most cases of rheumatoid arthritis, the patient's blood tests positive for rheumatoid factor and/or certain other antibodies (anti-cyclic citrullinated peptide (CCP)-antibodies).
- These positive blood tests indicate the patient has seropositive rheumatoid arthritis, meaning the patient possesses the antibodies that cause an attack on joints and lead to inflammation.

Seronegative (Category M06)

- Patients can develop rheumatoid arthritis without the presence of these antibodies. This is referred to as seronegative rheumatoid arthritis.
- Seronegative patients are those who do not test positive for rheumatoid factor or anti-CCPs.

Rheumatoid Arthritis in Remission

- Rheumatoid arthritis is a chronic and incurable systemic condition that affects the patient for the rest of their life.
- With early and aggressive treatment, many patients can achieve long periods of remission in which inflammation is greatly reduced or absent with no active signs of disease.
- Rheumatoid arthritis described as "in remission" should be coded when it requires or affects patient care, treatment or management – if there are no contradictions or conflicts elsewhere in the record that suggest rheumatoid arthritis is not a true or confirmed diagnosis.

Without rheumatoid factor information, the Alphabetic Index defaults this to code *M06.9, Rheumatoid arthritis, unspecified*, even when the specific joint involvement is documented

Coding Basics: Autoimmune Disorders-Rheumatoid Arthritis

Long-Term (Current) Use of Immunosuppressant & Immunomodulating Drugs

- Immunosuppressant drugs are commonly used in the treatment of autoimmune diseases such as rheumatoid arthritis for the express purpose of suppressing the immune system.
- A code for adverse effect is not assigned when the medication has achieved its intended result in lowering the patient's immune response to rheumatoid arthritis. Rather, assign code D84.821, Immunodeficiency due to drugs.
- For systemic autoimmune diseases like rheumatoid and psoriatic arthritis, support may be found in disease-modifying antirheumatic drugs (DMARDs), including, but not limited to:

  - Methotrexate
  - Hydroxychloroquine
  - Azathioprine
  - Sulfasalazine
  - Leflunomide
  - Cyclosporine
  - Gold salts
  - D-penicillamine
  - Minocycline

- Biologic tumor necrosis factor (TNF)-inhibiting DMARDs include, but are not limited to:

  - Etanercept
  - Infliximab
  - Adalimumab
  - Certolizumab
  - Golimumab

- Biologic no-TNF DMARDs include, but not limited to:

  - Rituximab
  - Anakinra
  - Abatacept
  - Tocilizumab
  - Sarilumab
  - Tofacitinib

Knowledge Application – Case Review

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Case Review #1
Insufficient Documentation & Coding

Reason for Appointment: Lab results and back pain

History of Present Illness: 30 y/o male patient comes to the office to discuss lab results. He has prediabetes and ankylosing spondylitis. He states he always has back pain. He denies any other signs or symptoms at this moment.

Current Medications: Medications reviewed and reconciled during the current visit.

Taking: Meloxicam 15 mg tablet 1 tablet orally once a day, Metformin HCl - 500 mg 1 tablet with a meal orally once a day, Enalapril Maleate 5 mg tablet 1 tablet, Methotrexate 2.5 mg tablet 6 tab(s) once a week orally

Past Medical History: Prediabetes, Ankylosing spondylitis.

Surgical History: Cyst removal 01/01/2005, Tonsillectomy 01/01/2016.

Review of Systems

- Constitutional: No weight loss, no fever, no chills, no weakness or fatigue
- HEENT: Eyes: No visual loss, no blurred vision, no double vision or no yellow sclerae; Ears, nose, throat: No hearing loss, no sneezing, no congestion, no runny nose or sore throat
- Skin: No rash or itching
- Cardiovascular: No chest pain, no chest pressure, no chest discomfort. No palpitations, no edema
- Respiratory: No shortness of breath, no cough, no sputum
- Gastrointestinal: No anorexia, no nausea, no vomiting, no diarrhea, no abdominal pain/blood in stool

Case #1 (Continued)
Insufficient Documentation & Coding

Vital Signs

Ht 5 ft 9 in, Wt 237 lbs, BMI 34.99 Index, BP 120/78 mm Hg, HR 82/min, RR 16/min, Temp 98.1, Pain scale 0 1- 10, Ht-cm 175.26, Wt-kg 107.5

Physical Examination

- General Appearance: Healthy-appearing
- Neck/Thyroid: No lymphadenopathy, thyromegaly; no JVD, neck supple, cervical lymphadenopathy
- Heart: no murmurs, rubs, gallops
- Lungs: normal, no wheezes, rales, rhonchi
- Chest: Able to speak in complete sentences , no retractions or accessory muscle use
- Abdomen: normal , no ascites, organomegaly, or hernias present
- Musculoskeletal: normal appearing, normal ROM of all major joints/spine during normal exam movements

Case #1 (Continued)

Insufficient Documentation & Coding

Assessments and Treatment

1. Hypertension – **I10**. Pt was instructed about medication compliance, low diet, and regular exercise for blood pressure control **CORRECT/ADDED**

2. Elevated liver enzymes – **R74.8**. Lab: Hepatic function panel (ordered) Imaging: US abdomen limited (ordered) **CORRECT/ADDED**

3. Prediabetes – **R73.03**. LAB: Comprehensive Metabolic Panel (ordered) HbA1c (ordered) **CORRECT/ADDED**.

4. BMI 34.0 -34.9, adult – **Z68.34** Patient counseled on the importance of a balanced diet and was advised to exercise at least 150 minutes/week divided in 3-5 daily sessions. Diet/exercise reviewed with patient. Eat vegetables, fruits, whole grains, complex carbohydrate, lean meats (poultry/turkey), seafood, nuts, and fiber-rich foods. **CORRECT/ADDED.**
5. Obesity – **E66.9 CORRECT/ADDED**
6. Dietary counseling and surveillance – **Z71.3** Provided dietary counseling focusing on carbohydrate control and portion management. Advised limiting processed foods and sugary snacks. Will recheck HbA1c in 3 months. **CORRECT/ADDED**

7. Ankylosing spondylitis lumbar region – **M45.6 MISSED/ADDED**
   Continue Methotrexate 2.5 mg tablet 6 tab(s) once a week orally – **Z79.631 MISSED/ADDED**

Rationale: (Diagnosis was added. The provider noted in their active voice the patient has ankylosing spondylitis in the HPI. Per coding guidelines “Code all conditions that coexist or affect patient’s care”.)

Case Review #2
Insufficient Documentation & Coding

Reason for Appointment: Follow up with blood work results/mammogram

History of Present Illness:
Hypercholesterolemia: Diet: no specific diet. Statin therapy: Patient is currently taking Simvastatin and is tolerating it well. Exercising, no regular exercise.

Current Medications: Medications reviewed and reconciled during the current visit. Taking: Zyrtec 10 mg tablet 1 tab(s) orally once a day, Ibuprofen 600 mg tablet 1 tab(s) orally bid prn, Notes: PRN, Omeprazole 20 mg delayed release tablet 1 tab(s) orally once a day, Notes: PRN, Simvastatin 40 mg tablet take 1 tablet by mouth once a day at bedtime, folic acid 1 mg tablet 1 tab(s) once a day orally 90 days orally 1 time a day, Methotrexate 2.5 mg tablet 6 tab(s) once a week orally 90 days orally once a week, Triamcinolone Acetonide Topical 0.1% cream 1 app applied topically 3 times a day

Past Medical History: Hyperlipidemia, gastritis, esophageal reflux, constipation, kidney stones, migraine headache, psoriatic arthritis

Surgical History: ruptured appendix- appendectomy 2005, c section 1991 & 1999, tonsillitis 1989

Review of Systems: Review of all other systems is otherwise as above or negative

Vital Signs: Oxygen Sat % 97%, Temp 98.4 F, BP 132/82 mm Hg, Ht 61 in, Wt 173 lbs, BMI 32.68 Index, PL 74, Pain Scale 0, RR 18

Physical Examination:

- Head: symmetric, NC/AT, no temporal tenderness
- Eyes: normal eyelids, anicteric scleras, normal conjunctiva
- Mouth: no lesions, no exudates, no erythematous, mucosa pink
- Heart: RRR, normal S1S2, no murmur
- Lungs: clear to auscultation
- Abdomen: soft, NT/ND, BS present
- Extremities: psoriatic arthritis hands
- Skin: psoriatic lesions in both hands
- Neurological: AAO X 3

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Case #2 (Continued)

Insufficient Documentation & Coding

Assessments and Treatment

1. Mixed hyperlipidemia – **E78.2**. Stop simvastatin tablet, 40 mg, 1 tab(s), orally, once a day (at bedtime) Start Atorvastatin Calcium tablet, 40 mg, 1 tab(s), orally, once a day, 90 days, 90 tablet, refills 1.
   CORRECT/ADDED

2. Encounter for screening mammogram for malignant neoplasm of breast – **Z12.31**. Notes: f/u mammogram, pt advised. **CORRECT/ADDED**

3. Elevated hemoglobin A1c – **R73.09**. Lab: comprehensive metabolic panel (ordered), HbA1c (ordered).
   CORRECT/ADDED

4. Arthropathic psoriasis, unspecified – **L40.50. MISSED/ADDED**
   Rationale: The provider noted in the physical examination the patient has psoriatic arthritis and lesions of both hands. Diagnosis was added. Per coding guidelines “Code all conditions that coexist or affect patient’s care”

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Case Review #3
Sufficient Documentation & Coding

Reason for Appointment: Annual.

History of Present Illness: 60 yo female with Hx of Sjogren syndrome, Hashimoto's, chronic GERD and gastric polyps who presents to the office today requesting a referral to GI specialist for evaluation due to symptoms of rectal spasms/pain especially after running. Pt denies rectal bleeding, n/v/d, fever, or any other acute symptomatology. No other concerns at this time.

Current Medications: Medications reviewed and reconciled during the current visit. Taking:
Synthroid 100 Mcg tablet, Cimetidine 400 mg tablet, Estradiol 0.1 mg/24 hr. patch, Pilocarpine 5mg po tid, Plaquenil 200mg bid

Past Medical History: Sjogren's syndrome with unspecified organ involvement, Hypothyroidism, GERD

Surgical History: Hysterectomy 01/2001, Bilateral oophorectomy 01/2016 bunionectomy

Review of Systems:

- General/Constitutional: Chills denies. Fatigue denies. Fever denies
- Cardiovascular: Chest pain denies. Chest pain with exertion denies; Dyspnea on exertion denies. Orthopnea denies. Palpitations denies
- Musculoskeletal: Joint stiffness denies; Muscle aches denies; Painful joints denies
- Neurologic: Headache denies; Memory loss denies; Seizures denies; Tingling/numbness denies

Vital Signs:
Ht 5 ft 1 in, Wt 126 lbs, BMI 23.8 Index, BP 118/70 mm Hg, HR 60/min, RR 17/min, Temp 97.8 F, Oxygen sat % 98%, Pain scale 0 1-10, Ht-cm 154.94, Wt-kg 57.15

Physical Examination:

- General Appearance: Alert, well hydrated, in no distress
- Heart: Regular rate and rhythm, S1, S2 normal, no murmurs, rubs, gallops
- Lungs: Clear to auscultation bilaterally, no wheezes, rales, rhonchi. no retractions or accessory muscle use
- Abdomen: Bowel sounds present, soft, nontender, nondistended, no masses palpable, no hepatosplenomegaly

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Case #3 (Continued)
Insufficient Documentation & Coding

Assessments and Treatment

1. Annual visit for general adult medical examination with abnormal findings – **Z00.01.** **CORRECT/ADDED**
   Notes: Annual labs ordered today.
2. Hypothyroidism (acquired) – **E03.9.** **CORRECT/ADDED**

   Continue Synthroid tablet, 100 mcg – **Z79.890.** **CORRECT/ADDED**
3. Gastroesophageal reflux disease without esophagitis, continue Cimetidine tablet 400 mg – **K21.9.** **CORRECT/ADDED**
4. Gastric polyposis – **K31.7.** **CORRECT/ADDED**
   Following with GI. Last EGD done 12/2024
   Referral To: Gastroenterology
5. Sjogren's syndrome with keratoconjunctivitis sicca – **M35.01.** **CORRECT/ADDED**
   Notes: Diagnosed many years ago. Hx of punctual occlusion for symptomatic treatment. Pt will bring records next OV. Continue Pilocarpine for saliva production.
6. Rectal spasm – **K59.4.** **CORRECT/ADDED**
   Referral To: Gastroenterology

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Case Review #4
Sufficient Documentation & Coding

Reason for Appointment: Chest pressure, pain

History of Present Illness: 52-year-old patient; states “chest pressure" with a feeling of pressure behind her sternum. Denies fever, SOB, COVID-19 exposure. Denies chest pain on exertion, swelling of the legs. She wishes to get a continuation of care referral for her rheumatologist for her RA. She suffers from gastritis, states sometimes food feels "stuck" on her chest, she takes Pantoprazole on and off.

Current Medications: Medications reviewed and reconciled during the current visit. Taking: Pantoprazole Sodium 20 mg delayed release tablet, Methotrexate 7.5 mg oral weekly, ProAir HFA 108 (90 Base) MCG/ACT aerosol solution, vitamin D (Ergocalciferol) 50000 unit capsule

Past Medical History: Prediabetic, Rheumatoid arthritis, GERD

Surgical History: Appendectomy, colonoscopy, hysterectomy for benign fibroids (rt. ovary removed due to cysts)

Review of Systems:

- Respiratory: Cough denies. Shortness of breath denies. Wheezing denies.
- Cardiovascular: Chest pain denies. Chest pain with exertion denies. Dyspnea on exertion denies. Orthopnea denies. Palpitations denies
- Gastrointestinal: Abdominal pain denies. Blood in stool denies. Change in bowel habits denies. Constipation denies. Diarrhea denies Heartburn denies. Vomiting denies
- Musculoskeletal: Joint stiffness denies. Muscle aches denies. Painful joints denies.

Vital Signs:

Ht 5 ft 4 in, Wt 233 lbs, BMI 39.99 Index, BP 110/70 mm Hg, HR 88/min, RR 17/min, Temp 98.3 F

Physical Examination:

- General Appearance: alert, pleasant, in no distress
- Abdomen: bowel sounds present, soft, nontender, nondistended, no masses palpable, no hepatosplenomegaly
- Lungs: Respiration appears unlabored, with no audible cough
- Chest: Able to speak in complete sentences
- Neurologic: Alert and oriented, cooperative with the exam

Case #4 (Continued)
Insufficient Documentation & Coding

Assessments and Treatment

1. Chest pain, unspecified type – **R07.9.** **CORRECT/ADDED**
   Clinical Notes: The discomfort could be related to her RA, her gastritis, or asthma.
2. Gastritis, continue Pantoprazole 20 mg qd – **K29.70.** **CORRECT/ADDED**
3. Mild intermittent asthma – **J45.20.** **CORRECT/ADDED**
   Clinical Notes: Controlled, denies cough or wheezing.
4. Rheumatoid arthritis – **M06.9.** **CORRECT/ADDED**
   Continue Methotrexate 7.5 mg oral weekly – **Z79.631.** **CORRECT/ADDED**
   Referral To: Rheumatology Reason: RA; chest discomfort; chronic lower back pain
5. BMI 39.0-39.9, adult – **Z68.39.** **CORRECT/ADDED**
6. Obesity, unspecified – **E66.9.** **CORRECT/ADDED**

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Additional Education Available

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  - Diabetes Mellitus
  - HIV
  - Major Depression and Bipolar Disorders
  - Seizure Disorders
  - Obesity/BMI
- Supplemental Claims Submission
- Provider Vista

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