Florida Blue | MEDICARE

Medicare Risk Adjustment Testing, Coding, and Documentation Tip Sheet

Behavioral Health

The PHQ-9 is a multipurpose patient health questionnaire that helps physicians screen, diagnose, monitor, and measure the severity of depression.

By incorporating DSM-V-TR depression diagnostic criteria with other leading major depressive symptoms, it acts as a brief self-report tool. The PHQ-9 rates the frequency of the symptoms that factor into the scoring severity index.

Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation. A follow-up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's ability to function.

A primary care physician can bill for depression screenings in limited instances:

- During a regular evaluation and management service unrelated to depression and the ICD-10 code for the evaluation and management is a non-mental health code
- When conducted as part of the Annual Wellness Visit, Medicare allows independent review of status of depression. Applicable modifiers and ICD-10 codes apply.
- Outlier situations unrelated to preventive and wellness visits where these screening and counseling services may be covered

Make sure you also address socially sensitive conditions (alcohol and substance abuse).

Vascular Disease

Document medical history and physical exam such as:

- Ankle-brachial index (ABI) test (compares blood pressures of the ankle and arm)
- Laboratory testing (e.g., blood testing for elevated cholesterol or diabetes)
- Ultrasound of the lower extremities (angiography of the arteries of the lower extremities)

Metabolic Morbid Obesity

BMI	Associated Condition
30.0-34.9	Class 1 (overweight)
35.0-39.9	Class 2 (obese)
40 or >	Class 3 (morbidly obese)

BMI alone is not a weight diagnosis; it is a tool for determining weight diagnosis. Measure BMI each patient visit, once or twice annually. Document explicitly if patient is overweight, obese or morbidly obese. Make sure to link and code associated conditions.

Note: Coders should use the physician's statement to assign the E66 code; they should not infer a weight diagnosis on BMI calculations, lab values, or other measurements.

COPD

Document the manifestation using appropriate linkage terms, (e.g., “with obstructive chronic bronchitis” or “due to chronic obstructive asthma”).

Substantiate in the medical record with documentation such as:

- Spirometry results of FEV1/FVC ratio of less than 0.70
- History of chronic asthma and frequent episodes of bronchitis or pneumonia
- Results and interpretations of chest X-rays, labs, mucous tests, etc.

Document the current status of the COPD condition (stable, worsening, improved, followed up by a pulmonologist, etc.).

Document the following about the treatment:

- A clear and concise treatment plan for COPD, linking related medications to the diagnosis
- Orders for diagnostic testing with indication in the office note to whom or where the referral or consultation is made, or from whom consultation advice is requested, if referrals are made or consultations requested
- When the patient will be seen again, even if only on an as-needed basis

Chronic Kidney Disease

The National Kidney Foundation defines the stages of chronic kidney disease (CKD) according to the patient’s glomerular filtration rate (GFR), a diagnostic laboratory test that measures kidney function. GFR calculation is based on the patient’s age, race, gender, height, weight, and blood creatinine levels.

The provider will use the GFR and other findings to document the stage of the CKD. CKD classifies to codes in category N18. The fourth character of each code identifies the stage 1 through 5 based on the severity of the condition, as shown in the table below.

CKD requiring chronic dialysis classifies to N18.6 even when the condition is not specifically documented as end-stage renal disease. Note that code assignment is based on physician documentation of the specific stage and not the GFR alone.

Chronic Kidney Disease Stages

Stage	GFR	Description	ICD-10 Code
1	90+	Normal kidney function but urine findings, structural abnormalities, and genetic trait point to kidney disease	N18.1
2	60-89	Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease	N18.2
3	30-59	Moderately reduced kidney function; some damage to kidneys which are not working as well as they should	N18.30
3a	45-59	Mild to moderate reduced kidney function	N18.31
3b	30-44	Moderate to severe reduced kidney function	N18.32
4	15-29	Severely reduced kidney function	N18.4
5	<15	Kidney failure not requiring dialysis	N18.5
6	<15	End stage renal disease (ESRD) requiring dialysis	N18.6