Johns Hopkins Health Plans Medicare Advantage

Clinical Documentation Integrity (CDI) Program 2025

MIS1285W05152025

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Section One: Risk Adjustment 101

What is Risk Adjustment?

- Risk Adjustment (RA) is a payment model by which government programs adjust the revenue to health plans based on the heath status of the covered population.

- A way to calculate what to pay a health provider based on a patient's use of health care services and the cost to those services.

- RA helps identify patients who may have a higher medical need

Why is RA Needed?

- Improve the overall health status of patients by ensuring patients are treated at least once a year for all chronic conditions
- Improve care coordination for patients with select chronic conditions by ensuring all conditions are tracked by primary care and treated by the appropriate specialty.
- Improve population health capabilities by ensuring complete and accurate registries to be used in care management and disease management programs.
- Improve the accuracy of capitated or value-based payments to providers through payer contracts by appropriately capturing disease burden of populations

RAF Significance for Patient's Care

- RAF (Risk adjusted Factor) is a score that identifies patient's overall health status.
- Assigned values (HCC) for chronic /acute conditions are considered and calculated into a risk factor.
- If relevant diagnoses are not properly documented and reported yearly, the health status of a patient is not accurately reflected. This results in inaccurate RAF scores for the member population overall.
- Therefore, the quality of documentation and coding is critical to entitle reimbursement to the health plan.

Importance of Complete and Accurate Documentation

- Supports accurate risk scores for patients.
- Diagnoses codes are documented and supported in the medical record.
- Coding and billing are synchronized with service provided.
- Ensures continuity of quality of care.
- Most diagnosis codes for risk adjustment are generated by primary care providers. Therefore, provider engagement plays a significant role in ensuring proper documentation for service provided to the patient.

Section Two:
2025 Clinical Documentation Integrity (CDI) Program

Consider the Following Common, Risk-Adjusted ICD-10 Diagnoses for Medicare Patients

DIABETES MELLITUS
Diabetes Mellitus Type II, unspecified (E11.9_)
DMII with renal complications (E11.2_)
DMII with ophthalmic complications (E11.3_)
DMII with neurologic complications (E11.4_)
DMII with periph. circulatory complications (E11.5_)
DMII with other specified complications (E11.6_)

CARDIOLOGY
Hypertensive heart disease with HF and CKD (I13.0)
Heart Failure, unspecified (I50.9)
Chronic Diastolic Heart Failure (I50.32)
Pulmonary Hypertension (I27.20)
Cardiomyopathy, unspecified (I42.9)
Chronic Atrial Fibrillation (I48.20)
paroxysmal Atrial fibrillation (I48.0)
Sick sinus Syndrome (I49.5)
Atrial Flutter (I48.92)
Supraventricular (paroxysmal) tachycardia (I47.1)
Angina Pectoris (I20.9)
CAD with Angina pectoris (I25.119)

VASCULAR DISEASES
Atherosclerosis of Aorta (I70.0)
Atherosclerosis of Lower Extremities; select laterality (I70.20--); select laterality
Abdominal Aneurysm (I71.4)
Thoracic Aortic Aneurysm (I71.2)
PVD (I73.9)
Chronic DVT, lower extremity (I82.50--); select laterality

RHEUMATOID ARTHRITIS & INFECTIOUS CONNECTIVE TISSUE DISEASE
Rheumatic Arthritis (M06.9)
SLE (M32.9)
Inflammatory Polyarthropathy (M06.4)

PULMONARY
- Chronic Bronchitis (J42)
- COPD / Respiratory Coditions (J44.9)
- Emphysema, unspecified (J43.9)
- Chronic Respiratory Failure (J96.11)
- Dependence on Oxygen (Z89.81)

CANCER
- Breast Cancer, Right (C50.911)
- Breast Cancer, LefT (C50.912)
- Colon Cancer (C18.9)
- Lung Cancer, Right (C34.91)
- Prostate Cancer (C61)
- CLL, in remission (C91.11)
- CLL, not in remission (C91.10)

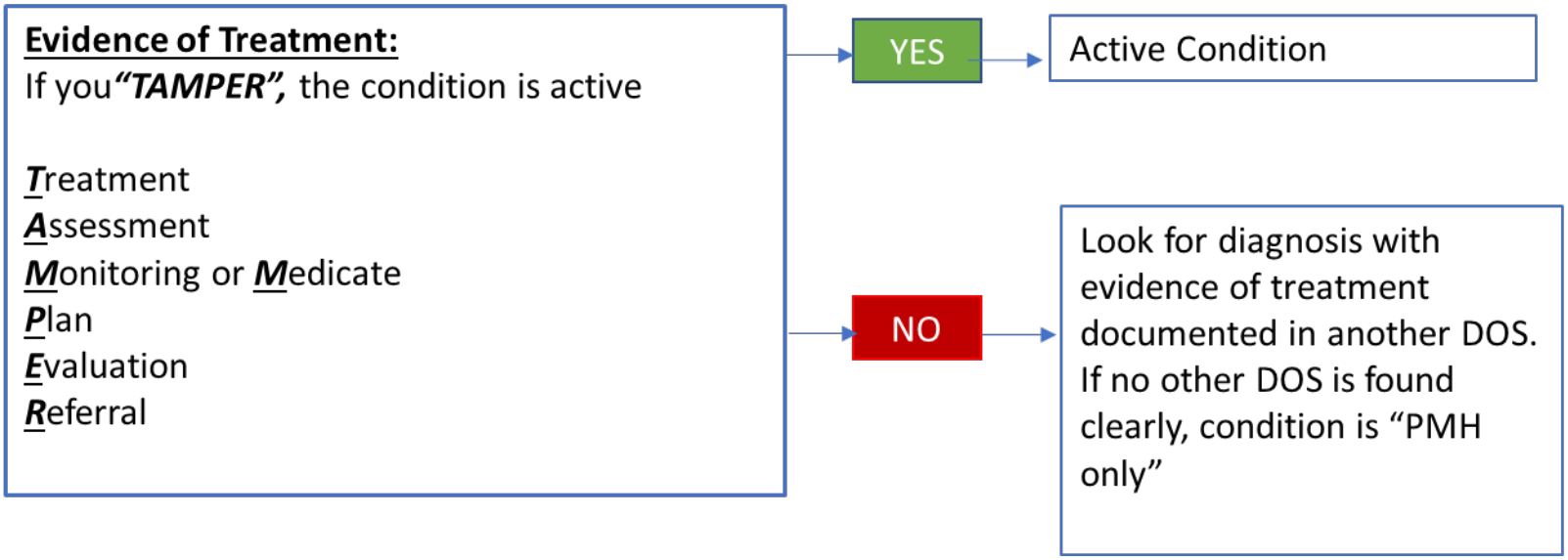
RENAL CONDITIONS
- CKD Stage 2 (N18.2)
- CKD Stage 3a (N18.31)
- CKD Stage 3b (N18.32)
- CKD Stage 4 (N18.4)
- CKD Stage 5 (N18.5)
- CKD, ESRD (N18.6 + Dialysis Status Z99.2)
- Secondary Hyperparathyroidism due to Renal (N25.81)
- AKI (N17.9)

MORBID OBESITY
- Morbid Obesity, Severely Obese (document morbid obese on exam) (E66.01)
- BMI 40 - 44.9 (Code also E66.--) (Z68.41)
- BMI 45 to 49.9 (Z68.42)
- BMI 35.0 to BMI 39.9 (Z68.39)
- Cachexia (Document Cachexia) (R64)
- Protein Calorie Malnutrition (E46)
- PCM, Mild (E44.1)

MENTAL HEALTH
- Bipolar Disorder (F31.9)
- MDD, Single episode, Mild (F32.0)
- MDD, Single episode, Moderate (F32.1)
- MDD, Single Episode, Severe (F32.2)
- MDD, Recurrent Episode, Mild (F33.0)
- MDD, Recurrent Episode, Moderate (F33.10)
- MDD, Recurrent Episode, Severe (F33.--)
- MDD, Recurrent Episode, in remission unspecified (F33.40)
- Alcohol, Dependence (F10.20)
- Opioid Dependence (F11.20)
- Alcohol dependence, in remission (F10.21)
- Opioid Dependence, in remission (F11.21)
- Anxiolytic, Sedative and Hypnotic Dependence (F13.20)
- Dementia w/o behavior disturbance (F03.90)
- Dementia with behavior disturbance (F03.91)

How to determine if a Diagnosis is Active?

❑ Yes if you TAMPER* IonHealthcare®,LLC



***To determine if a diagnosis is active, the diagnosis has evidence of TAMPER.**

Caution

- If the diagnosis is listed in PMH or history of, there is not documentation to support the diagnosis; therefore, it is not considered "active" per risk adjustment review.
- Only document diagnoses as "history of" or "PMH" when they no longer exist (previously treated)
- Problem list should not include diagnoses that have been resolved & should be reviewed during an annual visit.

Section Three:
Risk adjustment Coding Tips

Coding Tip - DM

- **Use the Most Specific ICD-10 Codes**
  - E11.9 (Type 2 diabetes w/o complications) should be avoided when complications exist.
  - Use combination codes (e.g. E11.65 for Type 2 diabetes w/hyperglycemia).
- **Capture All Applicable Manifestations**
  - Link diabetes to conditions like neuropathy (E11.40), nephropathy (E11.21), retinopathy E11.319).
  - Use proper documentation to support the linkage (e.g., "diabetes with…").
- **Avoid Common Documentation Errors**
  - Do not code "history of diabetes" if the patient has active diabetes.
  - Use Z79.4 for long-term insulin use when applicable.
- **Review and Update Diagnosis Annually**
  - Ensure all chronic conditions, including diabetes, are assessed and documented each year.
- **Align with TAMPER Criteria**
  - Proper documentation should reflect monitoring (A1C levels), treatment (medications), and management of complications.
- **Stay Updated with Coding Guidelines**
  - Review the latest ICD-10-CM updates and HCC model changes to ensure compliance.

ICD-10 Coding Multiple Choice Question

A 67-year-old patient presents for a routine follow-up for diabetes. The provider documents **E11.42 – Type 2 diabetes mellitus with diabetic polyneuropathy** in the Assessment/Plan. However, there is **no mention of neuropathy symptoms** (e.g., numbness, tingling, burning) in the history or physical exam. The provider states, "DM well controlled."

Which ICD-10 code is most appropriate based on the documentation?

A. E11.42 – Type 2 diabetes mellitus with diabetic polyneuropathy
B. E11.40 – Type 2 diabetes mellitus with diabetic neuropathy, unspecified
C. E11.9 – Type 2 diabetes mellitus without complications
D. G62.9 – Polyneuropathy, unspecified

ICD-10 Coding Multiple Choice Answer

✅ **Correct Answer:**

C. E11.9 – Type 2 diabetes mellitus without complications

Rationale:

There is no documentation in the note to support diabetic neuropathy or polyneuropathy. Without subjective complaints or objective findings, assigning E11.42 or E11.40 would be considered upcoding.

Coding Clarification: Diabetes with Polyneuropathy

E11.9 – Type 2 Diabetes Mellitus without complications

- **HCC 38**
- **RxHCC 31**

Difference in *RAF* Score:
E11.9 = 0.166
E11.42 = 0.166
Potential *RAF* increase:
0.000

E11.42 – Type 2 Diabetes Mellitus with Diabetic Polyneuropathy

- **HCC 37**
- **RxHCC 30**

Difference in RxHCC Score:
E11.9 = 0.171
E11.42 = 0.495
Potential RxHCC increase:
0.324

Section Four:
Frequently Asked Questions

FAQS

- **What is Risk Adjustment coding?**
  - A method used to **predict healthcare costs** based on patient diagnoses.
  - Ensures appropriate reimbursement and **accurate patient risk scores.**
- **How often should diagnoses be updated?**
  - **At least once per calendar year**, even for chronic conditions.
  - Each visit should include a review and **reassessment of all active conditions.**
- **What is TAMPER and why is it important?**
  - **T**reatment, **A**ssessment, **M**onitoring or **M**edicate, **P**lan, **E**valuation, **R**eferral – ensures diagnoses are **clinically supported.**
  - Help prevent **coding errors and audits.**
- **What are common documentation errors?**
  - Using outdated or **unspecified** diagnosis codes.
  - Failing to **link conditions** (e.g., diabetes with neuropathy).
  - Coding **resolved conditions as active.**
- **Can BMI be used alone to document obesity?**
  - No! **BMI codes (Z68.xx) must be supported** by a documented obesity diagnosis (E66.xx).
- **Why are history codes (Z-codes) important?**
  - Used when a disease **is no longer active but impacts care** (e.g., Z85.xx for history of cancer).
- **What happens if a condition is not coded?**
  - It **won't be factored** into the patient's risk score.
  - May lead to **underpayment and inaccurate risk stratification.**

Contact Information