2019

Study Guide:

C R C™
Risk Adjustment
Disclaimer
This course was current when it was published. Every reasonable effort has been made to assure the accuracy of the information within these pages. The ultimate responsibility lies with readers to ensure they are using the codes, and following applicable guidelines, correctly. AAPC employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free, and will bear no responsibility or liability for the results or consequences of the use of this course. This guide is a general summary that explains guidelines and principles in profitable, efficient healthcare organizations.

US Government Rights
This product includes CPT®, which is commercial technical data and/or computer data bases and/or commercial computer software and/or commercial computer software documentation, as applicable, which was developed exclusively at private expense by the American Medical Association, 515 North State Street, Chicago, Illinois, 60610. U.S. Government rights to use, modify, reproduce, release, perform, display, or disclose these technical data and/or computer data bases and/or computer software and/or computer software documentation are subject to the limited rights restrictions of DFARS 252.227-7015(b)(2) (November 1995), as applicable, for U.S. Department of Defense procurements and the limited rights restrictions of FAR 52.227-14 (June 1987) and/or subject to the restricted rights provision of FAR 52.227-14 (June 1987) and FAR 52.227-19 (June 1987), as applicable, and any applicable agency FAR Supplements, for non-Department of Defense Federal procurements.

AMA Disclaimer
CPT® copyright 2018 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommendation their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT® is a registered trademark of the American Medical Association

Regarding HCPCS Level II
HCPCS Level II codes and guidelines discussed in this book are current as of press time. The 2018 code set for HCPCS Level II were unavailable when published.
# Contents

## Chapter 1
### The Business of Medicine

- Coding as a Profession .......................................................... 1
- The Role of a Risk Adjustment Coder ..................................... 1
- The Hierarchy of Providers .................................................... 6
- The Different Types of Payers ................................................ 6
- Medical Necessity ................................................................. 6
- The Need for Privacy and Security ......................................... 7
- Fraud and Abuse ................................................................... 8
- Need for Compliance Rules and Audits. ................................. 8
- The OIG Work Plan ............................................................... 8
- What AAPC Will Do for You .................................................. 9

## Chapter 2
### Medical Terminology and Anatomy Review

- Introduction ................................................................. 15
- Medical Terminology .......................................................... 15
- Integumentary System ......................................................... 18
- Musculoskeletal System ....................................................... 20
- Cardiovascular System ....................................................... 22
- Lymphatic System ............................................................. 26
- Respiratory System (Pulmonary System) ............................ 28
- Digestive System ............................................................... 29
- Urinary System ................................................................. 30
- Reproductive Systems ......................................................... 30
- Nervous System ............................................................... 30
- Endocrine System ............................................................. 32
- Hematologic (Hemic) System ............................................ 32
- Immune System ............................................................... 33

## Chapter 3
### Introduction to ICD-10-CM

- Introduction .................................................................. 37
- Overview of ICD-10-CM Layout. ........................................... 37
Chapter 8
Clinical Documentation Barriers .................................................. 115
Signature or Credential Issues .......................................................... 115
Signatures in Risk Adjustment Data Validation (RADV or HRADV) .... 116
Past Medical History ........................................................................ 116
Lab and test Results ......................................................................... 116
Status Conditions ............................................................................ 116
Signs and Symptoms ....................................................................... 117
Uncertain Diagnosis ........................................................................ 117
Coding Clinic Guidance .................................................................. 118
Risk Adjustment Diagnosis CodingSteps ........................................ 119

Chapter 9
Frequently Coded Conditions in Risk Adjustment Models .............. 125
Acute vs. Chronic ............................................................................ 125
Differential Diagnosis ...................................................................... 125
Uncertain Diagnosis ........................................................................ 125
Risk Factors and Comorbidities ..................................................... 125
Sequelae (Late Effects) .................................................................... 125
Frequently Coded Conditions ........................................................ 127
Arteriovenous (AV) Fistula .............................................................. 140
Chronic Obstructive Pulmonary Disease (COPD) .............................. 141
Emphysema ................................................................................... 141
Asthma .......................................................................................... 142
Complications of Care .................................................................... 143
Congestive Heart Failure .............................................................. 143
Cor Pulmonale .............................................................................. 144
Deep Vein Thrombosis (DVT) ........................................................ 145
Dementia ....................................................................................... 146
Depression ..................................................................................... 146
Diabetes ........................................................................................ 146
Epilepsy & Convulsions .................................................................. 149
Gastroesophageal Reflux Disease (GERD) ........................................ 149
Hepatitis ....................................................................................... 150
Human Immunodeficiency Virus (HIV) ............................................ 151
Hypertension (HTN) ...................................................................... 152
Myocardial Infarction ..................................................................... 154
Neoplasms .................................................................................... 156
Neuropathy .................................................................................... 156
Pneumonia ......................................................................................................................... 157
Pulmonary Embolism ................................................................................................. 157
Rheumatoid Arthritis ................................................................................................. 159
Substance abuse ......................................................................................................... 160
Ulcers & Wounds .......................................................................................................... 161
Varicose Veins ............................................................................................................... 163
Vertebral Fractures ....................................................................................................... 163

End of Chapter Questions—Answers and Rationales .................................................. 175

Practice Examination .................................................................................................... 191

Practice Examination—Answers and Rationales ......................................................... 207
The Business of Medicine

Chapter 1

Coding as a Profession

Each time an individual receives healthcare, a record is maintained of the resulting observations, medical or surgical interventions, diagnostic test and studies, and treatment outcomes. Coding is the process of translating this written or dictated medical record into numeric and alphanumeric codes. There are separate code sets to describe diagnoses, medical and surgical services/procedures, and supplies. These code sets serve as a common language to ease data collection (eg, to track disease), to evaluate the quality of care, and to determine costs and reimbursements.

Proper code assignment is determined both by the content (documentation) in the medical record and by the unique rules that govern each code set in that particular instance. Coding rules also vary depending on who pays for the patient care (eg, self-pay vs. health insurance).

Coding typically is performed by either the physician or a coder. When the physician performs the coding, the coder may act as an auditor to verify that the documentation supports the codes the physician selected. In some practices, the coder will receive the documentation and code the services based on what is documented in the medical record.

If the medical record is inaccurate or incomplete, it will not translate properly to the language of codes. The coder must evaluate the medical record for completeness and accuracy and communicate regularly with physicians and other healthcare professionals to clarify diagnoses or to obtain additional patient information.

Outpatient coding focuses on physician professional services and outpatient facility coding. Outpatient coders will focus on CPT®, HCPCS Level II, and ICD-10-CM codes. They will work in physician offices, outpatient clinics, and facility outpatient departments. Outpatient facility coders will also work with Ambulatory Payment Classifications (APCs).

Hospital inpatient coding focuses on a different subset of skills, where coders will work with ICD-10-CM and ICD-10-PCS. These coders also will assign medical severity diagnosis related groups (MS-DRGs).

Risk adjustment coding focuses on diagnosis coding using the ICD-10-CM code set. Risk adjustment diagnoses are reported from claims data and medical record documentation in all settings. Risk adjustment coders may work for health plans or provider, or may work in other healthcare entities.

Regardless of the setting, code updates and insurance payment policies may change as often as quarterly. Coders require continuing education to stay abreast of these changes.

The Role of a Risk Adjustment Coder

Risk adjustment coders work in various roles. The main role for a risk adjustment coder is in a health plan or for a vendor who is working with a health plan. Risk adjustment coders also work in provider offices when the providers have risk-based contracts.

Risk adjustment coders need to know the complexity of diseases associated with chronic conditions or comorbidities to ensure the documentation supports an accurate health status of the patient. Payment to the Medicare Advantage Organization (MAO) depends on the diagnoses reported by a provider; therefore, proper documentation and coding is pertinent to proper reimbursement.

Some risk adjustment coders will be tasked with educating providers on proper documentation and coding. As such, a risk adjustment coder should have a well-rounded, firm knowledge of medications, treatments, and diagnostic tests to identify areas for improvement. For example, an educational opportunity exists if a patient is taking insulin, but the provider has not documented diabetes.

Because the goal is to represent an accurate clinical picture, and because risk adjustment coders are often required to code for other purposes, you must be able to apply the ICD-10-CM guidelines. Throughout this curriculum, we will first teach the application of the ICD-10-CM guidelines, then will apply risk adjustment guidelines. Unless otherwise noted, all documented diagnoses are to be coded, regardless of whether it is a risk-adjusted code.

Payer Perspective

Impact of risk adjustment

The Patient Protection and Affordable Care Act (ACA or "Obamacare") introduced risk adjustment to the mainstream. Although risk adjustment programs are subject to change every year, two factors remain the same:

1. These programs protect health plans from the risk of attracting a disproportionate number of unhealthy enrollees, while discouraging health plans from marketing to only healthier, less costly potential members.
Superficial (external)—Closer to the surface of the body.

Deep (internal)—Closer to the center of the body.

For radiological studies, the body is often virtually cut along a flat surface called a plane. The most frequently used planes include:

Sagittal—Cuts through the midline of the body from front to back, dividing the body into right and left sections.

Frontal (coronal)—Cuts at a right angle to the midline, from side to side, dividing the body into front (anterior) and back (posterior) sections.

Transverse (horizontal) (axial)—Cuts horizontally through the body, separating the body into upper (superior) and lower (inferior) sections.

Structure of the Human Body

The structure of the human body falls into four categories:

1. The cell is the basic unit of all living things. Human anatomy is composed of cells that vary in size and shape according to function.

2. Tissue is a group of similar cells performing a specific task; for instance, muscle tissue produces movement. Connective tissue is divided into four general groups: adipose tissue, cartilage, bone, and blood.

3. Organs are two or more kinds of tissue that together perform special body functions. As an example, the skin is an organ composed of epithelial, connective, and nerve tissue.

4. Systems are groups of organs that work together to perform complex body functions. For example, the nervous system is made up of the brain, spinal cord, and nerves. Its function is to coordinate and control other body parts.
Blood Vessels

Vessels—Arterial Circulation

Source: By LadyofHats, Mariana Ruiz Villarreal [Public domain], via Wikimedia Commons
38. Data is mined from various places to give additional information as it relates to risk scores. Which of the following data elements might be used in this process?
   I. Durable medical equipment requests
   II. Claims data (CPT®, HCPCS Level II, ICD-10-CM, etc.)
   III. Prescription drug events
      a. I and III
      b. II and III
      c. I and II
      d. I, II, and III

39. Insurance companies use a statistical process in which historical data is analyzed using algorithms to determine the likelihood of a future event. What is this process called?
   a. Risk management
   b. Predictive modeling
   c. Data management
   d. Provider feedback

40. Insurance companies use predictive modeling for:
   I. Recuperate money from the provider.
   II. Uncover potential current diagnoses that have not been reported on claims.
   III. Prepare for future needs of its members.
   IV. Provider education.
   V. Pay providers for additional diagnoses that have not been reported on claims.
      a. II and V
      b. I and IV
      c. II, III, and IV
      d. I, II, IV, and V