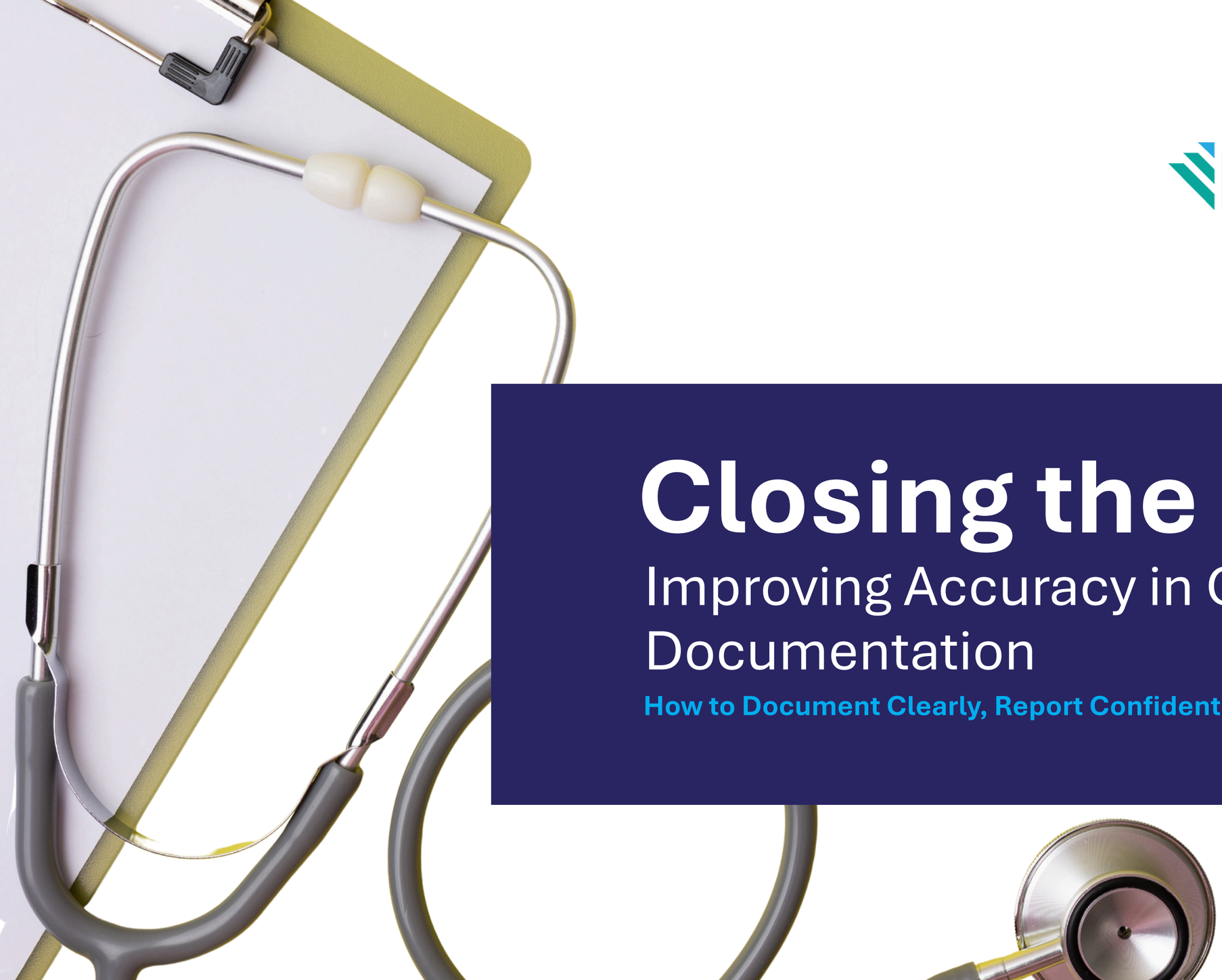

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Closing the Gaps:

Improving Accuracy in Chronic Condition Documentation

How to Document Clearly, Report Confidently, and Support Accurate HCC

Documentation That Drives Quality, Accuracy, and Risk Capture

Why Documentation Matters

- Accurate documentation is the foundation of coordinated and continuous care
- Chronic conditions drive treatment decisions, referrals, medical management, and monitoring
- Clear Documentation ensures every provider reviewing the chart understands the patient's true clinical picture

Impact on Risk Capture & Quality

- CMS uses only what is documented to determine patient complexity
- Under-documented conditions lead to inaccurate risk scores, affecting planning and resource allocation
- Strong documentation supports quality measures, preventive care, and chronic disease management
- Audit-ready documentation protects providers and organization from OIG and payor scrutiny

Why Chronic Conditions Are Commonly Under-Reported

- Conditions are clinically present but not explicitly assessed or documented during the visit
- Providers assume chronic conditions are "already known" or "in the chart"
- Problem list maybe outdated, incomplete, or not reconciled
- Lack of M.E.A.T./T.A.M.P.E.R. elements in conditions being removed during coding or audits
- Time pressure during visit leads to missed opportunities to validate chronic conditions

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CMS, OIG & ICD-10-CM Expectations

What CMS Excepts

- Chronic conditions must be evaluated and documented at least once every calendar year
- Documentation must clearly reflect the current status, not historical or assumed conditions
- Only conditions with M.E.A.T./T.A.M.P.E.R. support can be reported for risk adjustment
- CMS accepts what is documented, not what is clinically implied

What OIG Focuses On

- Validating of diagnoses through clear, specific, and clinically supported documentation
- Identification of unsupported, outdated, or copy-forward conditions
- Ensuring chronic conditions reflect active assessment, monitoring, or treatment
- Reducing improper payments tied to incomplete or vague documentation

ICD-10-CM Requirements

- Codes must reflect the highest level of specificity available
- Linkage terms (e.g., “with,” “due to,” associated with”) must be explicitly documented
- Chronic conditions require current assessment, not just presence on the problem list
- Accurate coding depends on clear provider documentation, not coder interpretation

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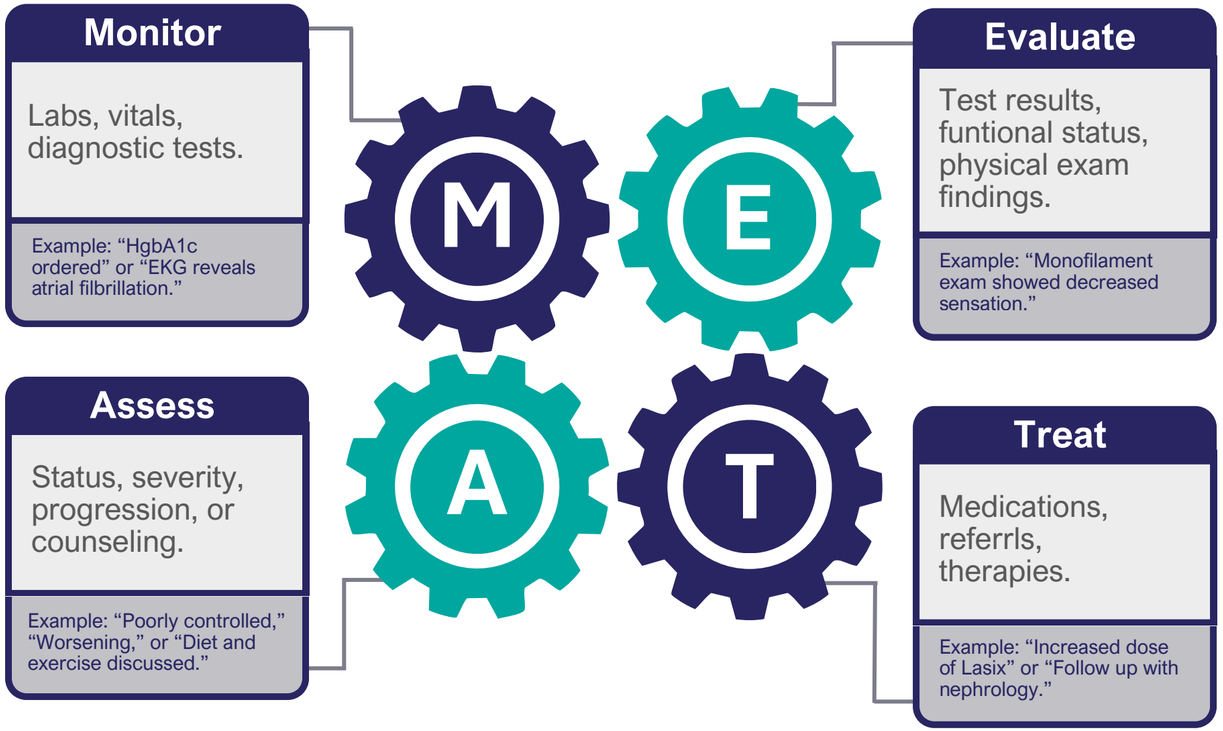
M.E.A.T./T.A.M.P.E.R. Essentials

M.E.A.T. - The Foundation of HCC Validation



T.A.M.P.E.R. – Strengthening Audit – Ready Documentation

Treat
The condition is being treated (medications, therapy, surgery, etc.).

Assess
The provider is evaluating the condition through history, exam, or data review.

Monitor
The condition is being followed over time with labs symptoms, or vitals.

Plan
The provider documents a plan of care (follow-up, medication changes, etc.).

Evaluate
Labs, tests, or diagnostics related to the condition are being interpreted.

Refer
The provider refers the patient to a specalist or additionial services.

Why M.E.A.T./T.A.M.P.E.R. Matters

- Validates chronic conditions for CMS risk adjustment
- Ensures documentation meets OIG audit expectations
- Supports accurate ICD-10-CM coding with clear clinical evidence
- Prevents removal of diagnoses due to insufficient documentation

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Why Chronic Conditions Fall Through the Cracks — And How to Meet CMS Validation Standards

Why These Conditions Are Missed

- Documented historically but not reassessed during the current encounter
- Problem list shows the condition, but no M.E.A.T./T.A.M.P.E.R. support in the note
- Condition is clinically stable; therefore, it not addressed
- Providers assume the condition is “already know” or “managed by another provider”
- Time-limited visits focus on acute issues, leaving chronic conditions unaddressed

High-Impact Conditions Often Under-Reported

- Chronic conditions that require annual evaluation but are frequently overlooked
- Conditions with specificity requirements (type, stage, acuity, linkage)
- Diagnoses that need clear clinical indicators to validate
- Conditions where documentation gaps lead to audit removals

What CMS Needs to See

- Current status: stable, worsening, uncontrolled, exacerbated
- Evidence of assessment, monitoring, or treatment
- Clear linkage between the conditions and labs, symptoms, or medications
- Documentation that reflects active management, not historical presence

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Common Clinical Conditions in the Outpatient Setting

- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Diabetes
- Status Conditions

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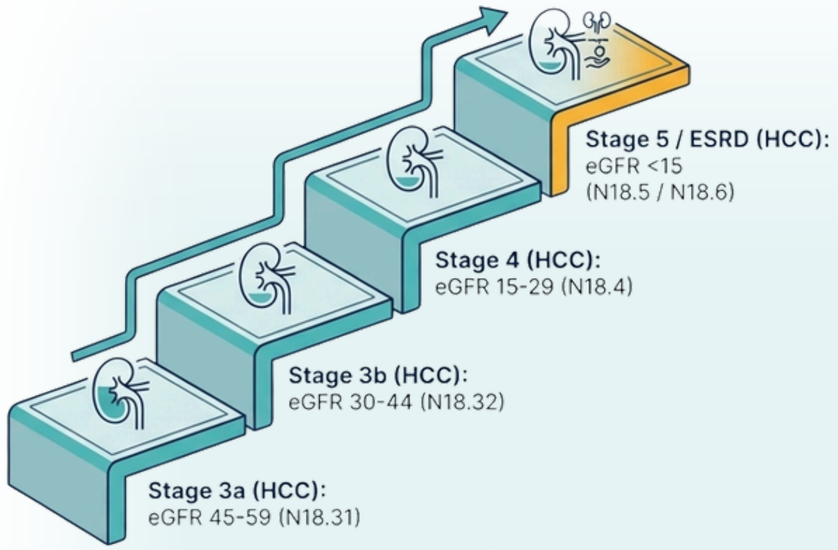
Chronic Kidney Disease

Blueprint: Chronic Kidney Disease (CKD) Staging



The Presumed Kinage Rule

A cause-and-effect relationship between Diabetes/CKD is presumed by coding guidelines.
The provider must clearly state if CKD is unrelated to the DM/HTN; otherwise, coders capture a combination code.

Always add status codes for Transplant (Z94.0) or Dialysis (Z99.2).

Stage	GFR	Code
Stage 1	GFR 90+	N18.1
Stage 2	GFR 60-89	N18.2
Stage 3a (HCC)	GFR 45-59	N18.31
Stage 3b (HCC)	GFR 30-44	N18.32
Stage 4 (HCC)	GFR 15-29	N18.4
Stage 5 (HCC)	GFR <15	N18.5
ESRD (HCC)	GFR <15	N18.6

(Note: Stages 1 and 2 do not carry an HCC value).

The MEAT Checklist

- **Include cause** if known (e.g., diabetic nephropathy).
- **Link to** underlying conditions (diabetes, hypertension).
- **Document complications** (anemia, hyperkalemia).
- **Add status codes**: Transplant (Z94.0) or Dialysis (Z99.2).

CKD Stage Documentation Tips

- Documentation of CKD should include the stage. Documentation of GFR/eGFR is not sufficient for assignment of stage.
- Documentation of CKD and HTN is coded to the HTN/CKD combination code (I12.0 or I12.9) unless the documentation states the CKD is not related to the HTN.
- Documentation should include the underlying etiology of CKD (HTN, DM, Obstruction, etc.)
- Documentation should include dialysis status or dialysis dependence, if applicable.

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Chronic Obstructive Pulmonary Disease

Avoid Vague Terminology.
Do not use 'chronic lung disease' or "reactive airway disease."

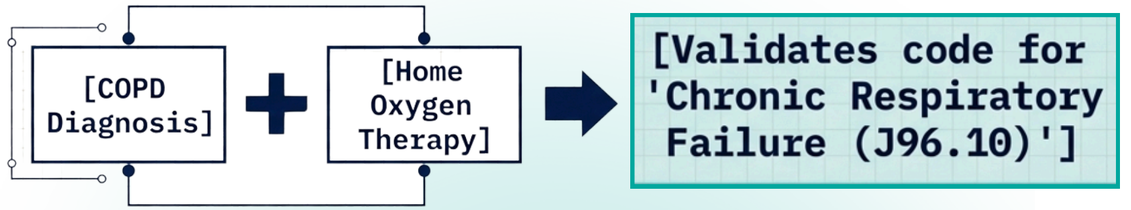
Use Precise ICD-10 Codes

- **J44.9** (Unspecified)
- **J44.1** (Acute exacerbation)
- **J44.0** (Lower respiratory infection)
- **J43.*** (Emphysema)

GOLD Staging (FEV1% Predicted):

M.E.A.T. Application

Always document tobacco use history (pack-years, quit, Z87.891 code), functional symptom impact (e.g., 'SOB walking 1 block'), and inhaler technique/adherence



M.E.A.T. Application

[M - Monitor]	[E - Evaluate]
ICD-10: Documented tobacco use history (40 pack-years, quit date 2018, Z87.891).	Functional symptom symptom impact: patient reports shortness of breath walking exactly 1 block.
[A - Assess]	**[T - Treat]**
ICD-10: Severe COPD, GOLD 3, frequent exacerbations.	Assessed inhaler technique and adherence; refilled Symbicd Symbicort.

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Congestive Heart Failure

Warning: Documentation Trap

Never document "CHF" without type or acuity. "History of CHF" is not active and not risk-adjustable.

The NYHA Classification Matrix

Class I: No physical limitation.	**Class II:** Slight limitation.
Class III: Marked limitation. (e.g., Chronic Systolic HF, NYHA Class III)	**Class IV:** Symptoms at rest.

Disease Multiplier Box

Documenting interacting conditions increases risk weight. Note linkages: CHF + DM (0.121), CHF + COPD (0.155).

Note: CHF + COPD on home oxygen validates coding for Chronic Respiratory Failure (J96.10).

HEART FAILURE

Documentation Requirements:

- **Acuity:** Acute, exacerbation/acute on chronic, or chronic
- **Type:** With reduces EF, with preserved EF or with diastolic dysfunction
- **If right side HF:** Document any associates conditions (i.e. pulmonary hypertension, acute or chronic cor pulmonate, etc.)

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Overview of Diabetes Mellitus (DM)

Type 1 DM

Autoimmune destruction of pancreatic beta cells → little or no insulin production

Codes to Category E10-

Type 2 DM

Insulin resistance ± reduced insulin production

Codes to Category E11-

Diabetes in Remission (as of 10/01/2025)

A patient with Type 2 diabetes meets criteria for “remission” when normal glycemic levels are maintained for at least three months without pharmacologic treatment for diabetes.

Codes to Category E11.A

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Diabetes Mellitus

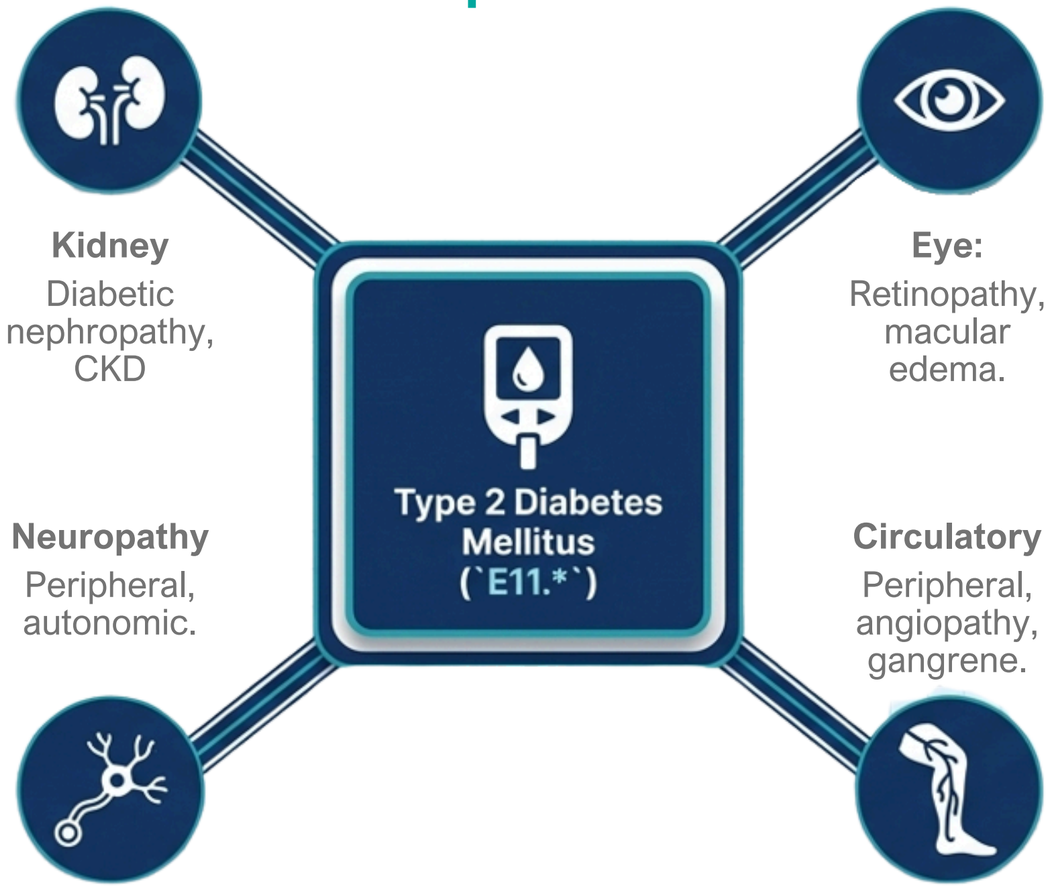
Required Specificity:

Documentation Include Control Status: It is controlled, exhibiting hyperglycemia, or hypoglycemia? Use objective values (e.g., “HbA1c 8.7% - uncontrolled”) to support the claim. Note any remission (e.g., post-bariatric surgery).

Applying the M.E.A.T. Framework:	
Monitored:	Labs (HbA1c, lipids, microalbumin), foot exams.
Evaluated:	Symptoms, macro/microvascular complications (e.g., diabetic retinopathy).
Assessed:	Control status, medication adherence, barriers to care.
Treated:	Medications, lifestyle, interventions, referrals, DSMES counseling.

Diabetes Mellitus with Complications

The Complication Web



M.E.A.T. Application

[M - Monitor]: HbA1c currently 8.4%.

[E - Evaluate]: Monofilament exam reveals peripheral neuropathy in bilateral feet.

[A - Assess]: Type 2 Diabetes with neuropathy, poorly controlled.

[T - Treat]: Adjusting basal insulin dose; patient educated on daily foot checks.

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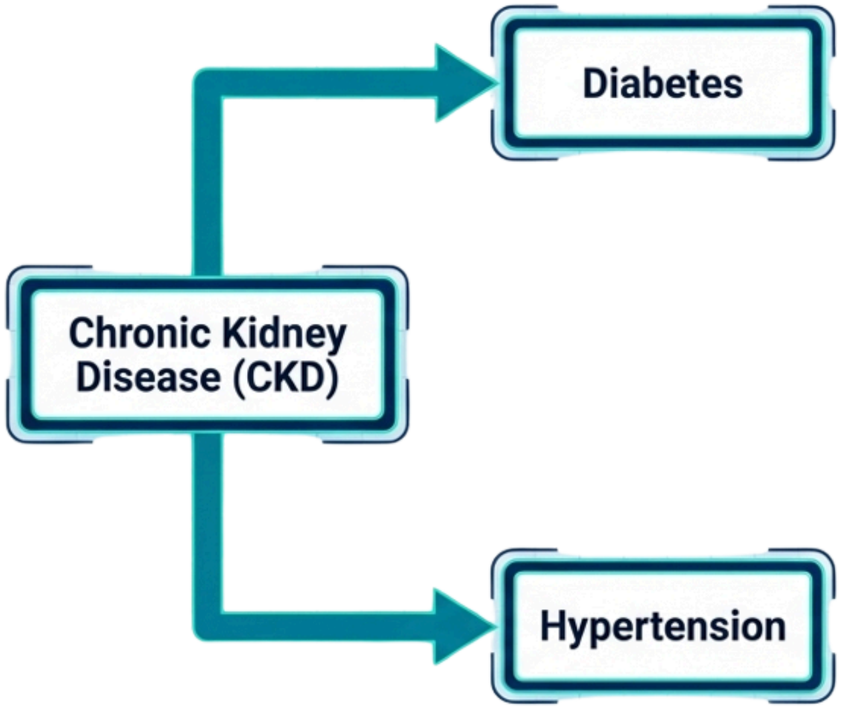
ICD-10-CM Complications of Diabetes Mellitus

ICD 10 Code	DIABETIC COMPLICATION(S) (add as many as needed)		GUIDELINES/TIPS
Type 2 Diabetes Mellitus WITH COMPLICATIONS	**ICD10 Code**	**Description**	**Any current diabetic medications need to be documented & reported:** • Long term (current) use of insulin – Z79.4 • Long term (current) use of oral hypoglycemic drugs – Z79.84 • Long-term (current) use of injectable non-insulin antidiabetic drugs – Z79.85 Code E11.A for Diabetes in remission should not be reported when a complication(s) is linked to diabetes. **Documentation tip:** All Complications related to diabetes, should be documented and linked to diabetes with words such as: • "due to" - "associated with" • "diabetic" - "related to" **Avoid Conflicting Documentation:** 1. Documenting and reporting Diabetes with and without complications for the same encounter 2. Documenting and reporting type 1 and type 2 Diabetes for the same encounter
	E11.22	Type 2 DM w/diabetic CKD Add code for complication: CKD stage (N18.XX)	
	E11.40/E11.42	Type 2 DM w/diabetic neuropathy or polyneuropathy	
	E11.51	Type 2 DM w/peripheral angiopathy (PVD)	
	E11.59	Type 2 DM w/other circulatory complications: Add code for complication: HTN (I15.XX)	
	E11.36	Type 2 DM w/diabetic cataract	
	E11.39	Type 2 DM w/other diabetic ophthalmic complication Add code for complication: Glaucoma (H40.XX)	
	E11.3XX	Type 2 DM w/diabetic retinopathy (select specific code)	
	E11.620	Type 2 DM w/diabetic dermatitis	
	E11.621	Type 2 DM w/foot ulcer (add specific ulcer code L97.XXX)	
	E11.630	Type 2 DM w/periodontal disease	
	E11.65	Type 2 DM w/hyperglycemia	
	E11.649	Type 2 DM w/hypoglycemia without coma	
	E11.69	Type 2 DM w/other specified complication: Add code(s) for complication(s): 1. Obesity/Morbid Obesity (E66.-) 2. Hyperlipidemia/ Hyperchylomicronemia (E78.-) 3. Heart complications (I25.-/I50/old MI)	

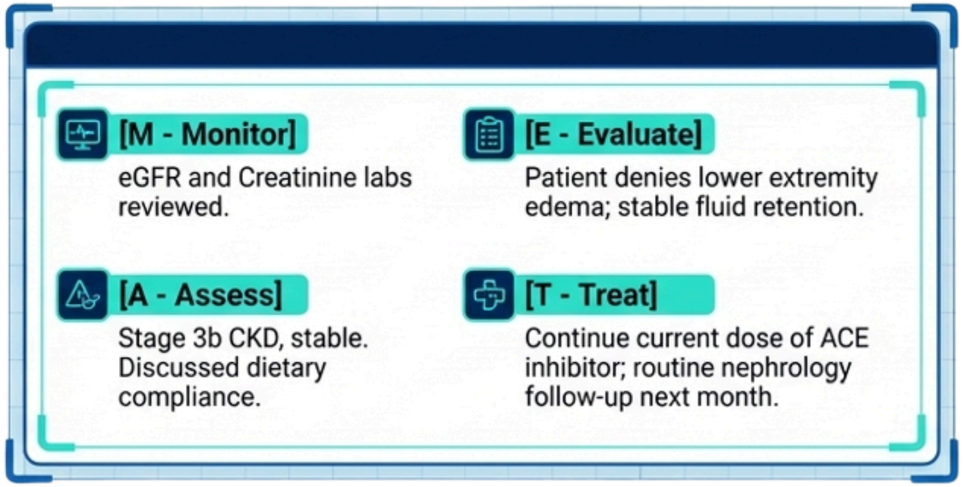
Specificity Documentation Example



The Presumed Linkage Rule

A cause-and-effect relationship between Diabetes/CKD and Hypertension/CKD is presumed by coding guidelines. The provider must clearly state if CKD is unrelated to the DM/HTN otherwise, coders are required to capture a combination code.

M.E.A.T. Application



	Condition Documented	ICD-10-CM Code and Description
Linkage	Diabetes and kidney issues	E11.9 – Type 2 DM without complications N18.9, Chronic kidney disease (CKD), unspecified
	Type 2 diabetes mellitus with CKD stage 3a with diabetic nephropathy	E11.22 – Type 2 DM w/ diabetic CKD N18.31, CKD stage 3a

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New Diagnosis Code - E11.A, Type 2 Diabetes Mellitus without Complications, in Remission

(effectice as of 10.01.2025)

What E11.A means clinically

This code is used when a patient:

- Has a documented history of type 2 DM
- Is currently not taking any diabetic medication(s)
- Has HbA1C levels consistently below 6.5%
- Has no active diabetic complications

Documentation must include

- The diabetes is “in remission”
- Method of remission (bariatric surgery, weight loss, lifestyle modification, etc.)
- Recent HbA1C values showing sustained control
- The patient is not diabetic medication
- The patient does not have an active diabetic complications

Why use E11.A

- Improved coding specificity
- Accurate representation of clinical status
- Supports risk adjustment and quality reporting
- Shows positive clinical outcomes while still acknowledging the underlying disease process

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Comparison of Active/Controlled Diabetes Mellitus vs True Remission

Active / Controlled (E11.*)	True Remission (E11.A)
• Patient relies on antidiabetic medications (oral, insulin, injectables). • HbA1c may be normal, but only due to active due to active pharmacologic therapy.	• Prior diagnosis of Type 2. • Zero current antidiabetic meds. • Sustained glycemic control via lifestyle alone. • HbA1c < 6.5% for at least 3 months.

FAQ / Guardrails

Resolved ≠ Remission. **E11.A** cannot be used for Type 1. If **A1C rises >6.5%, discontinue E11.A**. Do **not** use **E11.A** with **complication** codes (e.g., E11.42 polyneuropathy).

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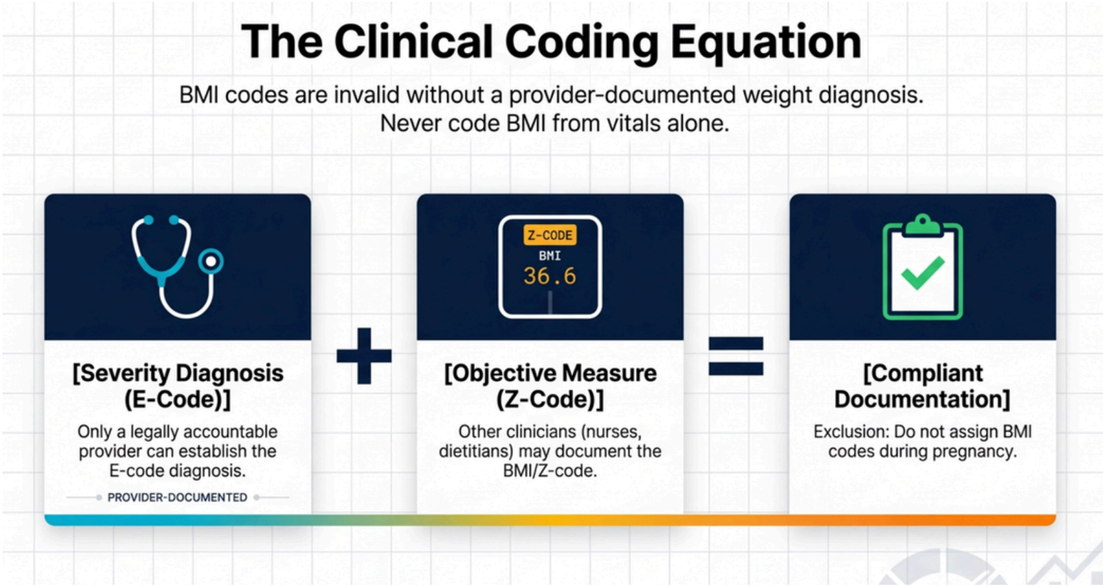
Improving Obesity Documentation: New Adult ICD-10-CM Codes Effective Oct 1, 2024

New E-Codes	Obesity Severity	BMI Range (kg/m2)
E66.811	Class 1 Obesity	30 to less than 35
E66.812	Class 2 Obesity	35 to less than 40
E66.813	Class 3 Obesity	40 or greater

+

Adult BMI Z Codes	Adult BMI
Z68.25-Z68.29	25-29.9
Z68.30-Z68.39	30.0-39.9
Z68.41	40.0-44.9
Z68.42	45.0-49.9
Z68.43	50.0-59.9
Z68.44	60.0-69.9
Z68.45	70 or greater

Reminder: **Please do NOT round BMI value for ICD10 code selection (ex. BMI 39.99 = Z68.39 (BMIs 39.0-39.9)**



April 2025 Rule Change: Obesity class codes **(E66.81)** now require a 5th character for severity. BMI must be documented to ensure complete, compliant records and close the clinical gap, overriding provider hesitation.

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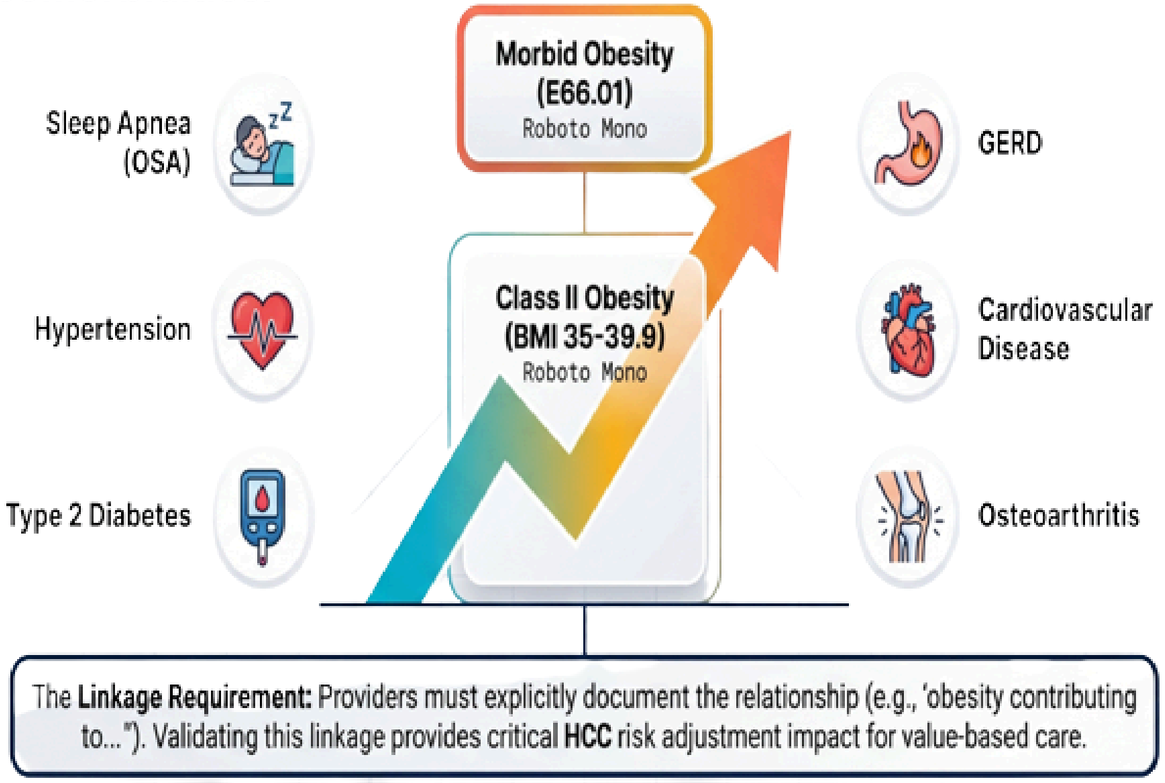
Documenting Class 2 Obesity: Linking Conditions to Support Correct Severity Coding

Class 2 Obesity (BMI 35.0 – 39.9) becomes clinically supported as "Morbid Obesity" E66.813 when linked to specific comorbidities.



Ensure every chosen E-code survives clinical audit.

M — Monitor
Track objective data.
EHR: Checking weight, BMI, and monitoring related lipid/glucose labs.

E — Evaluate
Assess physical impact and risks.
EHR: Evaluating how Class III obesity impacts poorly controlled hypertension.

A — Assess
Document counseling and barriers.
EHR: Discussed physical activity goals; patient reports difficulty maintaining calorie deficit.

T — Treat
Detail clinical interventions.
EHR: Referral to dietitian, initiated semaglutide, or evaluated for bariatric surgery.

Reminder: **Please do NOT round BMI value for ICD10 code selection (ex. BMI 39.99 = Z68.39 (BMIs 39.0-39.9)**

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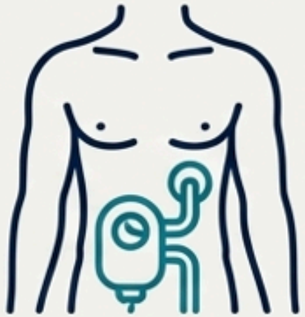
Status Conditions

Amputation Status

Acquired absence of ankle, foot, or leg (must specify above/below knee and laterality).

Major Organ Transplants

History of Heart, Lung, Bone Marrow, Liver, or Kidney transplant (Z94.0). Assess for post-transplant CKD stage.



Artificial Openings

Ileostomy, Colostomy (Z93.3), Gastrostomy. Must be current and documented.

Bariatric Status

History of bariatric surgery (Z98.84). Must be linked with current BMI and obesity counseling.

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Clinical Case Scenario

Chief Complaint:

Follow-up for chronic conditions management

Subjective:

Patient reports increased fatigue and mild shortness of breath with exertion. Denies chest pain. He has intermittent numbness in both feet. Reports increased cough and sputum over the past 3 days. No hypoglycemic episodes. No issues with prosthetic limb.

Objective:

- **Vitals**: BP 132/78, HR 88, RR 20, BMI 37.21
- **Labs**: A1c 8.7% (↑), eGFR 42 mL/min/1.73m² (stable), BNP mildly elevated
- **Physical Exam**:
  - Lungs: wheezing bilaterally
  - Cardiac: mild JVD, 2+ LE edema
  - Neuro: decreased monofilament sensation bilaterally
  - Extremities: Left BKA site intact, no skin breakdown

Assessment:

1. **Class 2 severe obesity (BMI 37.21) with Type 2 diabetes** – active - weight contributing to poor glycemic control.
2. **CKD stage 3b due to diabetic nephropathy** – stable eGFR unchanged; no electrolyte abnormalities.
3. **Acute on chronic systolic heart failure (HFrEF) —** mildly decompensated. Dyspnea ↑, edema present, BNP above baseline.
4. **COPD.** Increased cough, sputum, wheezing; O_2 sat 90% RA.
5. **Type 2 diabetes with stage 3b CKD and diabetic peripheral neuropathy** — uncontrolled. A1c 8.7%; neuropathy symptoms progressing.
6. **Status: Left below-knee amputation.** Residual limb intact; no complications.

Plan:

1. **Class 2 severe obesity with co-morbidity:** discussed lifestyle modification, offered GLP-1/SGLT2 for wight and glycemic benefit.
2. **CKD:** Continue ACE inhibitor; avoid nephrotoxins; repeat renal panel in 3 months.
3. **CHF:** Increase loop diuretic for 3 days; daily weights; reinforce sodium restriction; cardiology follow-up.
4. **COPD:** continue bronchodilators; recheck in 1 week, refer to Pulmonologist.
5. **Diabetes:** Adjust insulin regimen; reinforce SMBG; foot care counseling; podiatry referral; continue ACE inhibitor for renal protection.
6. **Status Condition:** Continue prosthetic care; reinforce daily skin checks.
7. **Follow-up:** Return in 4 weeks or sooner if symptoms worsen.

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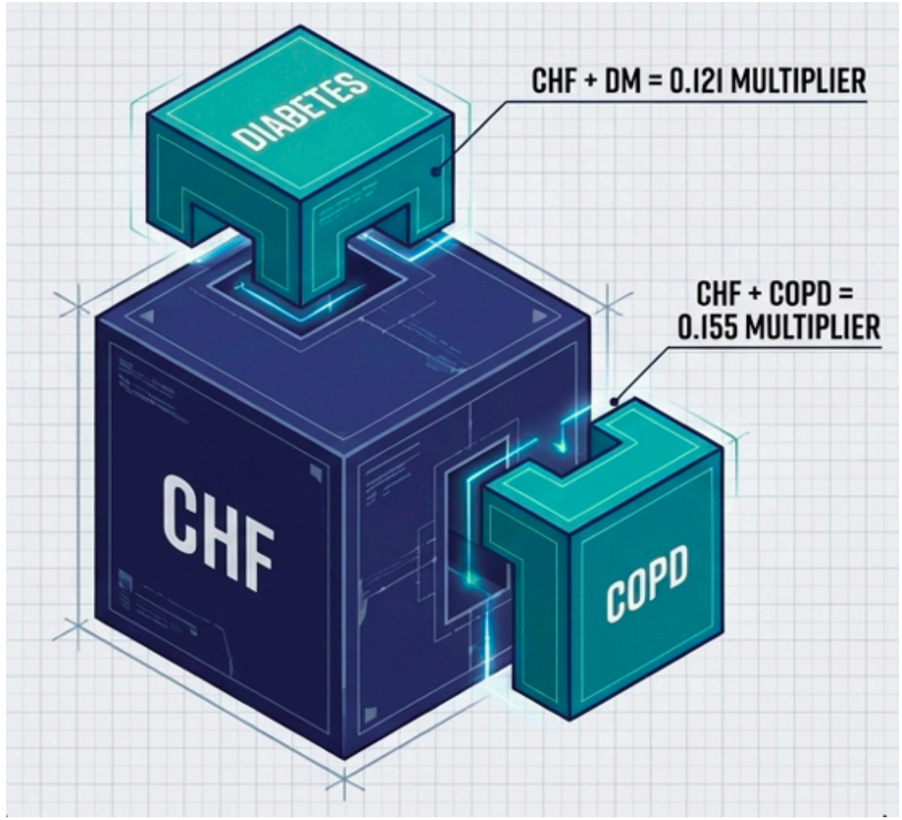
Disease – Disease Interaction and It's Impact on Risk Adjustment Factor Score

THE DISEASE MULTIPLIER BOX



M.E.A.T. APPLICATION

[M - MONITOR]

RECENT BNP ELEVATED AT 450.

[E - EVALUATE]

+2 PITTING EDEMA IN LOWER EXTREMITIES; FAINT CRACKLES AT BASES.

[A - ASSESS]

CHRONIC SYSTOLIC HEART FAILURE, NYHA CLASS III, WORSENING FLUID RETENTION.

[T - TREAT]

DOUBLED ORAL LASIX DOSAGE; STRICTLY LIMITING SODIUM INTAKE.

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Case Scenarios: Supported vs. Not Supported

Scenario 1 — Diabetes

- **Not Supported:** *DM on problem list. A1c reviewed.*
- **Supported:** *Type 2 DM — A1c 8.2% today. Uncontrolled. Increased metformin; follow-up in 3 months.*

Scenario 2 — CKD

- **Not Supported:** eGFR 42.
- **Supported:** *CKD stage 3b — eGFR trending down from 48 to 42. Monitoring renal function; avoiding nephrotoxic meds.*

Before: *History of CHF. No complaints.*

After: *Chronic systolic CHF — stable today. No edema or dyspnea. Continuing current meds; reinforced sodium restriction.*

Before: *Obese.*

After: Morbid obesity (BMI 42) — stable. Discussed weight-loss goals; patient starting nutrition program.

Avoiding Common Pitfalls

- **Name the condition clearly — don't rely on labs or vitals alone**
- **Document type, stage, acuity, and linkage when required**
- **Include MEAT/TAMPER elements in the visit note**
- **Avoid "history of" when the condition is active**
- **Link symptoms, labs, and treatment decisions to the diagnosis**

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Thank you for your time today. For any questions, please feel free to reach out to:

For inquires/questions please email at:
riskadjustmenthelp@peakhealth.org

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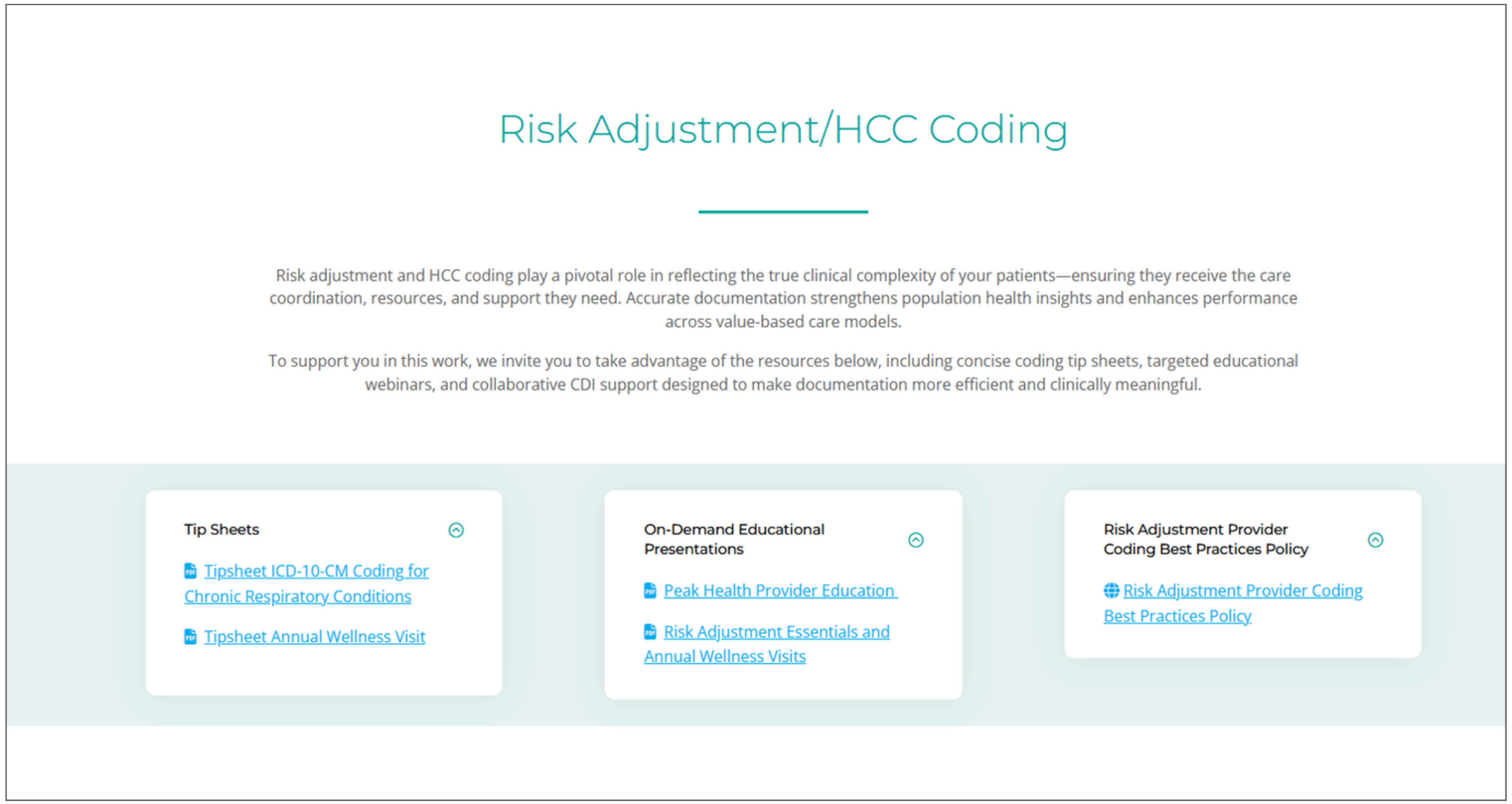
Where to Find the Webinars and Tipsheets

QR Code



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