OIG Targeted High Risk Condition Series

Session 4: Pulmonary Embolism (PE) and Deep Vein Thrombosis (DVT), Hepatitis & Cirrhosis

Virtual Conference

Thursday, May 1, 2025

Jointly provided by Healthfirst and Northwell Health

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OIG Targeted High Risk Condition Series
Session 4: Pulmonary Embolism (PE) and Deep Vein Thrombosis (DVT), Hepatitis & Cirrhosis

PROGRAM OVERVIEW

The purpose of this webinar series is to outline strategies and educate Healthfirst clinical providers on ICD-10 accuracy and clinical documentation improvement based on recommendations from the Office of Inspector General (OIG). The aim is to empower the providers and coders while enhancing the quality of healthcare delivery delivery.

Program components include, but are not limited to:

- Interactive sessions covering ICD-10 coding guidelines and documentation requirements.
- Case studies and examples illustrating coding scenarios and documentation challenges.
- Modules covering key aspects of ICD-10 coding and documentation improvement.
- Sharing experiences, tips, and strategies for improving documentation accuracy.

PROGRAM OBJECTIVES

Upon completion of this activity, participants should be able to:

- **Recall** the importance of accurate ICD-10 coding and documentation in healthcare.
- **Identify** common documentation pitfalls and errors impacting coding accuracy.
- **Apply** best practices for clinical documentation improvement to support accurate coding.
- **Comply** with OIG recommendations to minimize risks of improper payments and audits.

SESSION 4 OBJECTIVES

Pulmonary Embolism (PE) & Deep Vein Thrombosis (DVT)

- Identify a PE and/or DVT, laterality and specifics to select the most appropriate code and support whether it's truly active or historical and acute or chronic.

Hepatitis & Cirrhosis

- Describe the progression of liver disease, documenting the type of hepatitis and using more specific diagnosis codes while supporting the condition.

TARGET AUDIENCE

This activity has been planned by and for both physicians and clinical documentation & coding professionals. Medical providers such as PCPS and specialists in the areas of endocrinology, vascular, pulmonology, oncology, cardiology who treat chronically ill patients affected by these disease states and who will improve patient outcomes by enhancing their knowledge of ICD-10 coding are encouraged to join.

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ACCREDITATION STATEMENT

In support of improving patient care, this activity has been planned and implemented by Northwell Health and Healthfirst. Northwell Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE) and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

CREDIT DESIGNATION STATEMENTS

Physicians: Northwell Health designates each live activity for a maximum of 1.0 *AMA PRA Category 1 Credits™.* Physicians should only claim credit commensurate with the extent of their participation in the activity.

Verification of attendance: This will be provided to all professionals.

REGISTRATION

If you need additional information or to register for the event, please email Angela Sullivan, Manager of Provider Education, at asullivan@healthfirst.org or call 917-748-8455.

AGENDA

Thursday, May 1, 2025

8:55AM	Welcome and Introduction to CME Activity Richard Kops, MD *Medical Peer Reviewer* *Healthfirst*
Session	
9:00AM–9:45AM	OIG Targeted High Risk Conditions: Session 4: Pulmonary Embolism (PE) and Deep Vein Thrombosis (DVT), Hepatitis & Cirrhosis Damarys Ayala, MJ, RHIA, CRC, CPMA, CPC, CDEO *AAPC Approved Instructor Manager, Provider Education* *Clinical and Documentation Excellence* *Healthfirst*
9:45AM	Question and Answer Session
10:00AM – Adjournment	

AAPC - Continuing Education Units (CUEs)

- This webinar is approved by **American Academy of Professional Coders (AAPC)**
- Only registered participants will be eligible for CEUs.
- To receive a CEU certificate, You must attend at least 45 minutes of the webinar.
- Participants must be connected to both the audio and visual parts of the meeting for attendance to be recorded.
- After attendance is verified, an AAPC CEU certificate will be emailed to the appropriate participants.
- Sharing or claiming a CEU certificate without attending the webinar is strictly prohibited and could be viewed as fraudulent by AAPC.

DVT, PE, Chronic Hepatitis C & Liver Cirrhosis

Clinical Documentation & Coding Dept.

Information Sharing

Presenter: Damarys Ayala, MJ, RHIA, CRC, CPMA, CPC, CDEO
AAPC Approved Instructor
Manager, Provider Education

Date: 05/1/2025

Agenda

- Provider Education Program & Goals
- OIG Toolkit Overview
- Documentation and Coding Recommendations
  - Deep Vein Thrombosis
  - Pulmonary Embolism
  - Chronic Hepatitis C
  - Liver Cirrhosis
- HF Provider Portal

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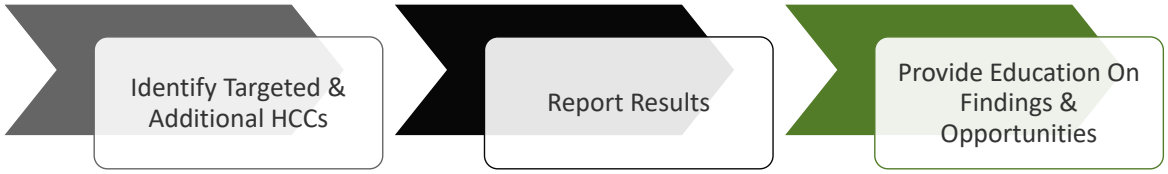
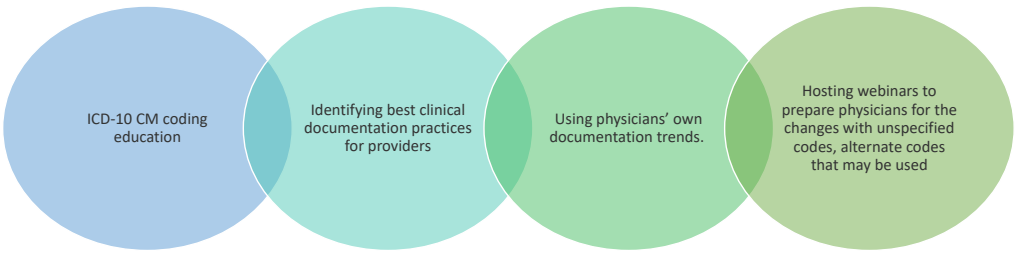
RADV Internal Surveillance Audit



Strategies Used to Improve Results



***Our goal is to emphasize the importance of documenting specificity so that the coder/physician select the most accurate and most appropriate diagnosis code while mitigating financial risk.**

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OIG Audit Findings for 2022-2024

NEW

Conditions in focus in 2024 reports:

- Sepsis
- Pressure Ulcers
- Ovarian Cancer

https://oig.hhs.gov/documents/audit/10142/A-07-22-01209.pdf

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Improving Documentation

- Providers must accurately document the patient's diagnoses for each visit (encounter). **MEAT** (Monitor Evaluate Assess Treat) is most used acronym to assist providers with documentation improvement tips.
- With the growing changes in healthcare, the need to expand clinical documentation has also grown…from **MEAT** to **TAMPER**!

	M.E.A.T.	T.A.M.P.E.R.
MONITOR	✓	✓
EVALUATE	✓	✓
ASSESS	✓	✓
TREAT	✓	✓
PLAN		✓
REFERRAL		✓

TAKE IT UP A NOTCH!

Treat	Assess	Monitor	Plan	Evaluate	Referral
Medications Therapies Other modalities	Review records, specialist and consultation notes, discharge summaries Order lab and diagnostic tests Discuss and counsel	Signs and symptoms Disease progression Disease recession	Diet exercise Therapy Return to office Considering surgical procedures	Test results (i.e., labs/diagnostic tests) Medication effectiveness Treatment response	Prescriptions for referrals to specialists for documented chronic conditions

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Deep Vein Thrombosis (DVT)

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Coding Example for DVT

DOS	12/06/2023
Diagnosis	I82.409 Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
HCC Category	HCC 267 - Deep Vein Thrombosis and Pulmonary Embolism
Diagnosis Supported	No
HCC Validated	No
Coding Rationale	Hx Vs Active
Comments	Documentation specifies PMH of DVT of LLE in 2022. Patient has Eliquis stopped by unknown provider, and a repeat doppler is negative.
Recommendation	Z86.718 Personal history of other venous thrombosis and embolism

History of Present Illness

HPI:

57 y/o female with extensive PMHx including Low back/thoracic spine pain, primary hyperparathyroidism (which is being worked up by endo), well controlled DM and Hx of DVT. Comes to the office for F/U.

Past Medical History

OA.
Lumbar Radiculopathy.
Anaphylactic Reaction.
CPS.
DVT of LLE (2022).
Mild degenerative spondylosis.

Physical Examination

Internal Medicine 2:

General comfortable, no distress , A&o X3 (Oriented to Person, Place, & Time).
Head normocephalic, atraumatic.

Assessments

7. Venous insufficiency - I87.2
8. Hyperparathyroidism - E21.3
9. Abdominal hernia without obstruction and without gangrene, recurrence not specified, unspecified hernia type - K46.9
10. Deep venous thrombosis - I82.409

10. Deep venous thrombosis

Clinical Notes: -Patient had Eliquis stopped by unknown provider?
-Repeat Doppler negative

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DVT Documentation Recommendations

Describe DVT	Laterality	Specific Vein	Complications	Symptoms	Diagnostic Evaluation	Treatment
☐ Acute (new)	☐ Right	☐ Femoral	☐ Postthrombotic syndrome	☐ Swelling in affected extremity	☐ Duplex Ultrasound	☐ Increased mobilization
☐ Chronic (longstanding)	☐ Left	☐ Iliac	☐ Pulmonary Embolism	☐ Pain	☐ Venography	☐ Compression stockings
☐ Date of DVT		☐ Popliteal	☐ Thrombophlebitis	☐ Redness of the Skin	☐ MRI	☐ Lower leg exercise
☐ Recurrent DVT (is this chronic?)		☐ Tibial		☐ D Dimer blood test	☐ CT Scan	☐ Thrombectomy
		☐ Peroneal		☐ Activated protein C resistance	☐ INR	☐ Vena Cava filter insertion
		☐ Calf muscle veins		☐ Antithrombin III Levels		☐ Link the diagnosis and purpose of anticoagulant therapy
				☐ Antiphospholipid antibodies		
				☐ Lupus anticoagulant		
				☐ Protein C and S levels		

Documentation Tip:
When documentation states, “pt is on an anticoagulant”, it should be specified whether the medication is given prophylactically or as a treatment for chronic DVT.

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Documentation Tips

Do Not	Document deep vein thrombosis as resolved if the condition is current.
Do Not	Document a suspected or unconfirmed diagnosis as if it were confirmed.
Do Not	Describe current chronic DVT as “history of” or “past medical history”. “history of” & “past medical history” means the condition is historical and no longer exists.
Do Not	Use terms that imply uncertainty such as “probable,” “apparently,” “likely,” “consistent with,” etc. to describe a confirmed peripheral vascular disease condition (out pt setting only).

Acute
A new and often symptomatic thrombosis is found, and the patient is starting anticoagulation therapy.

(Commonly a duration of up to 3 months)

Chronic
Old or established which requires ongoing anticoagulation therapy & can be recurrent.

Historical
Patient no longer has thrombosis but is taking anticoagulation therapy prophylactically.

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Q & A

TRUE or FALSE

A suspected thrombosis of left lower extremity should be reported on an outpatient visit.

Q & A

TRUE or FALSE

A suspected thrombosis of left lower extremity should be reported on an outpatient visit.

FALSE

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Coding Example for DVT

DOS	10/25/2023
Diagnosis	I82.409 Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
HCC Category	HCC 267 - Deep Vein Thrombosis and Pulmonary Embolism
Diagnosis Supported	No
HCC Validated	No
Coding Rationale	Hx Vs Active
Comments	Documentation specifies PMH of DVT in 2020 & Surgical hx 2021; ROS – denies all
Recommendation	Z86.718 Personal history of other venous thrombosis and embolism

History of Present Illness

Cardiovascular 06/22:

PMHx HHD, DVT (6/2020 Montefiore), AICD, Cardiac Arrest, Angina. Pt reports she had an angiogram Mt. Sinai recently. Pt ran out of Ranolazine and has been doing okay so she does not want refills of ranolazine.

Denies : Chest Pain. Denies : Shortness of Breath. Denies : Dyspnea on Exertion. Denies : Orthopnea. Denies : PND. Denies : Palpitations. Denies : Dizziness. Denies : Syncope. Denies : Diaphoresis. Denies : Fatigue. Denies : Ulcers. Denies : Cold Extremities. Denies : Impotence.

Past Medical History

DVT.
AICD.
Chronic back pain.
Hep C treated.
Third degree burns left arm back chest.
Cardiac arrest.

Surgical History

DVT 6/2021
Cholecystectomy
Appendectomy
Left foot
AICD
Left ankle

Assessments

1. Cardiac arrest - I46.9 (Primary)
2. AICD (automatic cardioverter/defibrillator) present - Z95.810
3. DVT (deep venous thrombosis) - I82.409
4. Nicotine dependence - F17.200
5. Hypertensive heart disease without heart failure - I11.9

3. DVT (deep venous thrombosis)

Clinical Notes: Isolated event. Unclear if provoked or unprovoked.

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Deep Vein Thrombosis – ICD-10 Codes

ICD-10 CM	Description	ICD-10 CM	Description
Acute embolism and thrombosis of lower extremity		**Chronic embolism and thrombosis of lower extremity**	
I82.41*	Femoral vein	I82.51*	Femoral vein
I82.42*	Iliac vein	I82.52*	Iliac vein
I82.43*	Tibial vein	I82.53*	Tibial vein
I82.44*	Calf muscular vein	I82.54*	Calf muscular vein
I82.45*	Peroneal vein	I82.55*	Peroneal vein
I82.46*	Calf muscular vein	I82.56*	Calf muscular vein
I82.49*	Other specified deep vein of lower extremity	I82.59*	Other specified deep vein of lower extremity
Acute embolism and thrombosis of upper extremity		**Chronic embolism and thrombosis of upper extremity**	
I82.62*	Deep veins of upper extremity	I82.72*	Deep veins of upper extremity
I82.A1*	Axillary vein	I82.A2*	Deep veins of upper extremity
I82.B1*	Subclavian vein	I82.B2*	Subclavian vein
I82.C1*	Internal jugular vein	I82.C2*	Internal jugular vein
I97.89	Other postprocedural complications and disorders of the circulatory system, not elsewhere classified		
T82.868A	Thrombosis due to vascular prosthetic devices, implants and grafts, initial encounter		
Personal history of other venous thrombosis and embolism			
Z86.718	Personal history of other venous thrombosis and embolism		

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Q & A

Patient had DVT in June of 2024. The clots have resolved but pt is still taking anticoagulants. Would this now be coded as history of DVT Or chronic DVT with current use of anticoagulants?

A.History of DVT
B.Chronic DVT
C.DVT on anticoagulants

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Q & A

Patient had DVT in June of 2024. The clots have resolved but pt is still taking anticoagulants. Would this now be coded as history of DVT Or chronic DVT with current use of anticoagulants?

A.History of DVT
B.Chronic DVT
C.DVT on anticoagulants

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Pulmonary Embolism (PE)

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Coding Example for PE

DOS	2/25/2023
Diagnosis	I26.99 Other pulmonary embolism without acute cor pulmonale
HCC Category	HCC 267 - Deep Vein Thrombosis and Pulmonary Embolism
Diagnosis Supported	No
HCC Validated	No
Coding Rationale	Hx Vs Active
Comments	Pt was seen in ED and discharged. Pt has a documented history of PE. No evidence that PE is current, therefore should not be reported as an active condition.
Recommendation	**Z86.711** Personal history of pulmonary embolism

Chief Complaint:
Chief Complaint
Patient presents with
- Urinary Tract Infection

History of Present Illness:
62 yo M with hx of Afib, cancer, CHF, HTN , PE and recurrent UTI coming in for UTI. Pt states he was here last week and was found to have a stone, upon chart review, pt has 4mm stone and was admitted but left AMA.
Pt return now bc states he has a uti and dysuria and back pain.
Pt denies fever, chills, cough, chest pain, sob, n/v/d, abdominal pain, headache, dizziness, syncope, weakness or paresthesia/paralysis.

History:
Past Medical History:
Diagnosis
- A-fib (HCC)
- Anemia
- Cancer (HCC)
- CHF (congestive heart failure) (HCC)
- GERD (gastroesophageal reflux disease)
- Hypertension
- Ileostomy in place (HCC)
- Pulmonary embolism (HCC)
- Stroke (cerebrum) (HCC)

Review of Systems:
Review of Systems
Constitutional: Negative.
HENT: Negative.
Eyes: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Gastrointestinal: Negative.
Endocrine: Negative.
Genitourinary: Negative.
Musculoskeletal: Positive for back pain.
Skin: Negative.
Allergic/Immunologic: Negative.
Neurological: Negative.
Hematological: Negative.
Psychiatric/Behavioral: Negative.

Assessment and Plan:
62 yo M with hx of Afib, cancer, CHF, HTN , PE and recurrent UTI coming in for UTI. Pt states he was here last week and was found to have a stone, upon chart review, pt has 4mm stone and was admitted but left AMA, now returning for UTI
-pt with no chest pain or shortness of breath
-labs, ua, ucltx
-will send home on cipro

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PE Documentation Recommendation

Type of Pulmonary	Status of Condition	Signs & Symptoms	Complications	Diagnostic Testing	Treatment
❑Infarction ❑Thrombosis ❑Thromboembolism	❑Stable ❑Improved ❑Worsening ❑Date of PE	❑Acute dyspnea ❑Pleuritic chest pain ❑Cough ❑Hemoptysis ❑Tachypnea ❑Tachycardia	❑With acute cor pulmonale ❑Septic (identify the underlying infection) ❑Other pulmonary heart diseases, for ex: ❑Pulmonary HTN ❑Heart failure	❑Chest X-ray ❑Pulse oximetry ❑Blood gas testing ❑ECG ❑CT angiography ❑D-dimer testing ❑Duplex ultrasonography	❑Supportive therapy ❑Anticoagulation (length of Tx) ❑Inferior vena cava filter placement ❑Surgical embolectomy ❑Extracorporeal membrane oxygenation ❑Other

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Q & A

Documentation of pulmonary embolism should include:

a) Date of onset of PE
b) Status
c) Treatment and plan
d) All of the above

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Q & A

Documentation of pulmonary embolism should include:

a) Date of onset of PE
b) Status
c) Treatment and plan
d) All of the above

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Coding Example for PE

DOS	7/7/2023
Diagnosis	I26.99 Other pulmonary embolism without acute cor pulmonale
HCC Category	HCC 267-Deep Vein Thrombosis and Pulmonary Embolism
Diagnosis Supported	No
HCC Validated	No
Coding Rationale	Hx Vs Active
Comments	PE documented as historical (2013) with a clear statement that it was "treated with warfarin." This is not a present condition and should not be reported with an active code.
Recommendation	**Z86.711** Personal history of pulmonary embolism

HPI:

1. Rectal cancer with lung nodules and lymphadenopathy, details as below.
2. Essential thrombocytosis.
3. Anemia with iron deficiency, has a component of ACD, also has had plasma cell dyscrasia (IgG kappa).
4. Hyperhomocystinemia with vitamin B12 deficiency.
5. PE (2/13), treated with warfarin.
6. Prolonged PTT.
7. Other comorbid conditions include DM, BPH, hypothyroidism, CKD and peripheral neuropathy.
8. Post-surgery for leg fracture and cataract surgery.
9. EGD showed chronic gastritis and colonoscopy showed diverticulosis (10/20).

Past Medical History

H/o rectal cancer 2010 (colostomy on llq).
Essential thrombocytosis.
Hyperhomocytinemia with Vit amin B 12 def.
PE 2013 s/p warfarin tx.
DM.
BPH.
Peripherral neuropathy.
Hypothyroidism.

Assessments

1. Rectal cancer - C20 (Primary)
2. Anemia of chronic disease - D63.8
3. Iron deficiency anemia - D50.9
4. Essential thrombocytosis - D47.3
5. Monoclonal gammopathy - D47.2
6. Intestinal malabsorption, unspecified - K90.9
7. Lung nodules - R91.8
8. Lymphadenopathy - R59.1
9. B12 deficiency - E53.8
10. Pulmonary embolism - I26.99
11. Abnormal coagulation profile - R79.1
12. Essential hypertension - I10
13. Prostatism - N40.0
14. Chronic kidney disease (CKD) - N18.9

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Q & A

TRUE or FALSE
Documentation of “Septic pulmonary embolism without acute cor pulmonale”, should include the underlying infection.

a) True
b) False

Q & A

TRUE or FALSE
Documentation of “Septic pulmonary embolism without acute cor pulmonale”, should include the underlying infection.

a) True
b) False

Pulmonary Embolism ICD-10-CM Codes

ICD-10 CM	CODE DESCRIPTION
Pulmonary Embolism With Acute Cor Pulmonale	
I26.01	Septic pulmonary embolism with acute cor pulmonale *Code first underlying infection
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale
I26.03	Cement embolism of pulmonary artery with acute cor pulmonale *Code first complication of other artery following a procedure (T81.718)
I26.04	Fat embolism of pulmonary artery with acute cor pulmonale Code first if applicable: *Complication of other artery following a procedure (T81.718) *Traumatic fat embolism (T79.1) (T79.1-T79.1XXS)
I26.09	Other pulmonary embolism with acute cor pulmonale
I27.82	Chronic pulmonary embolism *Use additional code, if applicable, for associated long-term (current) use of anticoagulants (Z79.01)

ICD-10 CM	CODE DESCRIPTION
Pulmonary Embolism Without Acute Cor Pulmonale	
I26.90	Septic pulmonary embolism without acute cor pulmonale *Code first underlying infection
I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale
I26.93	Singe subsegmental thrombotic pulmonary embolism without acute cor pulmonale
I26.94	Multiple subsegmental thrombotic pulmonary emboli without acute cor pulmonale
I26.95	Cement embolism of pulmonary artery without acute cor pulmonale *Code first complication of other artery following a procedure (T81.718)
I26.96	Fat embolism of pulmonary artery without acute cor pulmonale *Code first, if applicable: Complication of other artery following a procedure (T81.718) Traumatic fat embolism (T79.1)
I26.99	Other pulmonary embolism without acute cor pulmonale

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Chronic Hepatitis C

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Coding Example Chronic Hep B

DOS	2/26/2023
Diagnosis	B18.0- Chronic viral hepatitis B with delta-agent
HCC Category	HCC 65 - Chronic Hepatitis
Diagnosis Supported	No
HCC Validated	Yes
Coding Rationale	HCC Validated
Comments	Documentation supports chronic hepatitis B without delta agent as there was no indication of chronic hep b with delta.
Recommendation	Correct diagnosis code - B18.1 - Chronic viral hepatitis B without delta-agent

HPI:

New symptom(s):

H/O heptitis B virus positive. no abdominal pain. no nause .no vomit.no fever. appetite OK. patient need do sonogram every 6 months. patient need follow up by gi every year. patient need do blood test every 3 month to check liver function test. heptitis B virus loading and afp level.patient need come back for blood test and sonogram for follow up. need evaluate the medication use policy every 3 months. patient need good rest and no alcohol! Discuss with the patient smoker education and care management after the patient underwent annual screenings for depression. alcohol and drug abuse. and smoking.

Assessment:

Assessment:
1. Chronic viral hepatitis B without delta-agent - B18.1 (Primary)
2. Type 2 diabetes mellitus without complications - E11.9
3. Irritant contact dermatitis, unspecified cause - L24.9
4. Encounter for screening for other disorder - Z13.89

mz.

Plan:

Treatment:
1. Chronic viral hepatitis B without delta-agent
Notes: Patient Educated with: Self Management Goal: Hepatitis B Lifestyle Management Diet Control of light.pdf (HEP B (1) NO Med.pdf)

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Chronic Hepatitis C Documentation Recommendations

Specify Type/Acuity

- ☐ Acute hepatitis C
- ☐ Chronic viral hepatitis C
- ☐ With hepatic coma
- ☐ Without hepatic coma

Status of condition

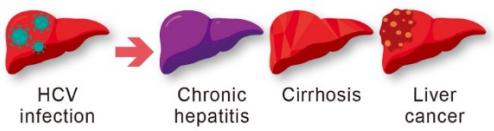
- ☐ Stable
- ☐ Improved
- ☐ Worsening
- ☐ Resolved (liver implant)

Associated Conditions

- ☐ Level of specificity of hepatitis
- ☐ Cirrhosis of liver
- ☐ Hepatorenal syndrome
- ☐ Hepatopulmonary syndrome
- ☐ Hepatic failure
- ☐ Malignant neoplasm of liver and intra-hepatic bile ducts
- ☐ Alcoholic liver disease

Medical Management

- ☐ Ordered tests i.e Viral Load
- ☐ Treatment
- ☐ Follow up
- ☐ Surveillance
- ☐ Referrals



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Q & A

Documenting specificity of the condition will lead to?

a) Capturing severity of the diagnosis
b) Patients' true health status
c) Both a and b

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Q & A

Documenting specificity of the condition will lead to?

a) Capturing severity of the diagnosis
b) Patients' true health status
c) Both a and b

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Coding Example Cirrhosis Of Liver

DOS	6/2/2023
Diagnosis	K74.60-Unspecified Cirrhosis Of Liver
HCC Category	HCC 64 - Cirrhosis of Liver
Diagnosis Supported	Yes
HCC Validated	Yes
Coding Rationale	HCC Validated
Comments	Unspecified liver cirrhosis of liver is supported in the A/P with medication.

Reason for Appointment

1. Dizziness
2. f/u HTN, diabetes and hyperlipidemia.

History of Present Illness

Depression Screening:
PHQ-2 (2015 Edition) Little interest or pleasure in doing things? Not at all, Feeling down, depressed, or hopeless? Not at all, Total Score 0.
Hx of Illness:
Patient I have mild dizziness soemtimes, no nausea, and relieved some with rest, no fever, no headache, no other neurological complaints. I want to have medication at home.
DM:
Denies : Symptoms Weight Gain, Weight Loss, Polyphagia, Polydipsia, Polyuria.
Control: Moderate control, fasting glucose around 120-130mg/dl. Diet Cooks mostly at home, Adequate fiber intake. Environmental Stress Moderate. Exercise Rarely. Self Management Goals Addressed, Encouraged personal behavioral changes of better glucose control, exercise and healthy eating, also here for flu vaccine and complaint of some bothersome dry rashes.

3. Hyperlipidemia, unspecified - E78.5
4. Vitamin D deficiency, unspecified - E55.9
5. Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease - I12.9
6. Collapsed vertebra, not elsewhere classified, lumbar region, initial encounter for fracture - M48.56XA
7. Hypothyroidism, unspecified - E03.9
8. Unspecified cirrhosis of liver - K74.60
9. Body mass index [BMI]30.0-30.9, adult - Z68.30
10. Chronic kidney disease, stage 3 unspecified - N18.30
11. Functional urinary incontinence - R39.81

7. Unspecified cirrhosis of liver
Refill Ursodiol Capsule, 300 MG, 1 cap, Orally, Twice a day, 90 days, 180 Capsule, Refills 1

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Documentation Tips

Do not use term "History of" if a patient still has an active viral infection.

For patients who have had a liver transplant documentation should include the transplant status code - along with medical management

- **Z94.4 Liver transplant status,**

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Q & A

What is the best way to describe and document a patient's current chronic hepatitis C diagnosis?

a) Document as "history of"
b) Document as "current" including viral load, acuity and type

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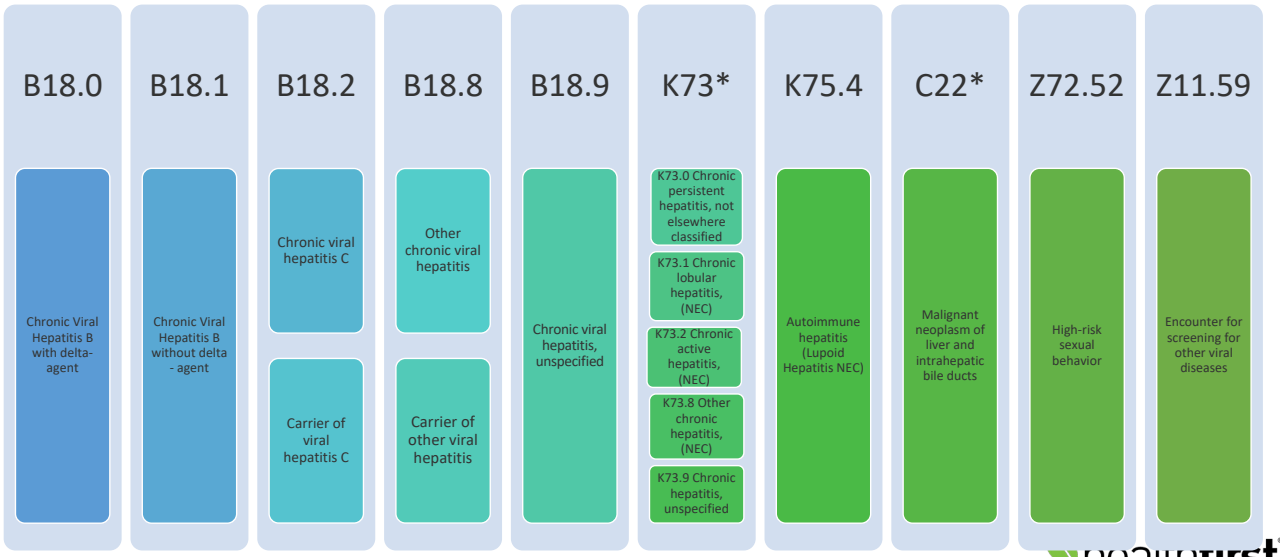
Chronic Viral Hepatitis ICD-10-CM Codes



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Liver Cirrhosis

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For illustrative purposes only

Coding Example Liver Cirrhosis

DOS	10/7/2021
Diagnosis	K74.69-Other cirrhosis of liver
HCC Category	HCC-64 - Cirrhosis of Liver
Diagnosis Supported	No
HCC Validated	Yes
Coding Rationale	HCC Validated
Comments	Pt is documented to have Chronic Viral Hep c and "Other cirrhosis of liver" in A/P.
Recommendation	Better code abstraction would be **K74.60 Unspecified cirrhosis of liver,** since the documentation does not specify the type of liver cirrhosis.

History of Present Illness:
Patient is a 59 y/o female with Chronic Hep C and Cirrhosis. She also has leg edema. She was treated for Hep C and achieved an SVR. Her last Colonoscopy in 2018. She is requesting info on Covid vaccine. She remains on Lasic 40 and Spironolactone 100mg daily, for leg edema. Leg edema is most prominent when walking.

Past Medical History:
General: Denies CAD, Diabetes, Elevated cholesterol, Hypertension.

Review of Systems:
General: chills, fatigue.
Constitutional Systems: chills.
Cardiology: Denies angina, arrythmias, bypass surgery, Chest pain, claudication, cyanosis, dyspnea, edema, heart attack, heart murmurs, heart valve replacement, high blood pressure, hypertension, palpitations, vascular problems.
Respiratory: Denies asthma, cough, emphysema/bronchitis, shortness of breath, swelling, wheezing.
Gastroenterology: abd pain, bloating, constipation.

Assessment:
Current Problems: B18.2 - Chronic Viral Hepatitis C K74.69 - Other Cirrhosis Of Liver R60.9 - Edema, Unspecified

Clinical Impression/Plan: Patient is a 59 y/o female with Chronic Hep C and Cirrhosis. She also has leg edema. She was treated for Hep C and achieved an SVR. Her last Colonoscopy in 2018. She is requesting info on Covid vaccine. She remains on Lasic 40 and Spironolactone 100mg daily, for leg edema. Leg edema is most prominent when walking. Sono and liver labs as below. Renew Lasix 40mg daily.

Plan:
Flu Imm No Admin Doc Colorectal Ca Screen Doc Rev Calc Bmi Norm Parame Docrev Cur Meds By E Pt Scrn Tbco Id As N Tobacco Non-User Acp Discuss-No Dscnmkr Docd

Renew Lasix 40 daily
Sonogram
CBC
LFT's
HCV viral titer
AFP
RTC to office after vaccines completed.

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Liver Cirrhosis Documentation Recommendations

Type of Hepatic Fibrosis
- Hepatic sclerosis
- Hepatic fibrosis with hepatic sclerosis
- **Primary biliary cirrhosis**
  - -Chronic nonsuppurative destructive cholangitis
  - -Primary biliary cholangitis
- Secondary biliary cirrhosis
- Unspecified biliary cirrhosis
- **Other cirrhosis of liver**
  - -Cryptogenic cirrhosis
  - -Macronodular cirrhosis
  - -Micronodular cirrhosis
  - -Mixed type cirrhosis
  - -Portal cirrhosis
  - -Postnecrotic cirrhosis
- -Unspecified cirrhosis of liver

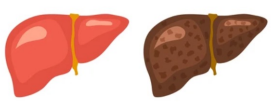
Status of Condition
- Stable
- Improved
- Worsening

Identify if Any
- Hepatitis
  - • Type
  - • Acute or Chronic
- Obesity
- Alcohol use/abuse/dependence
- Diabetes
- Other chronic condition

Complications
- Portal hypertension
- Edema
- Ascites
- Splenomegaly
- Bleeding
- Jaundice
- Acute on chronic cirrhosis

Diagnostic Tests
- Blood tests such as INR/Viral load
- High bilirubin levels
- Serum creatinine
- Screening for Hepatitis virus
- CT scan
- MRI Scan
- Ultrasound
- Biopsy

Treatment Plan
- Antiviral Medications
- Therapeutic endoscopy
- Trans-jugular intrahepatic portosystemic shunt
- Liver transplant
- Avoiding alcohol consumption
- Low sodium diet
- Diuretics
- Synthetic hormones



HEALTHY LIVER LIVER WITH CIRRHOSIS

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Q & A

Should the provider document any associated chronic conditions related to liver cirrhosis if the patient has any?

a) Yes
b) No

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Q & A

Should the provider document any associated chronic conditions related to liver cirrhosis if the patient has any?

a) Yes
b) No

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Coding Example Liver Cirrhosis

DOS	10/7/2021
Diagnosis	K74.60-Unspecified Cirrhosis Of Liver
HCC Category	HCC64 - Cirrhosis of Liver
Diagnosis Supported	Yes
HCC Validated	Yes
Coding Rationale	HCC Validated
Comments	Pt is documented to have Liver Cirrhosis and instructed to follow up with specialist. Pt is also currently on Spironolactone.

Current Medications

- Ursodiol,TABLET,500,mg/1, BID (Twice a day)
- furosemide,tab,20,mg/1, QD (Once a day)
- spironolactone,TABLET,25,mg/1, QD (Once a day)
- GLUCOPHAGE,TABLET, FILM COATED,1000,mg/1, BID (Twice a day)
- ferrous sulfate,tab,325,mg/1, QD (Once a day)
- Actos,TABLET,15,mg/1, QD (Once a day)

Drug Allergies

Not Reported

Blanca Zhinin is a 75 year old female, AAOX3 presents at home for health risk assessment. Patient has Liver Cirrhosis, Sarcodiosis. Educated patient about the importance of healthy diet, exercise, fall prevention and the need to follow up with his PCP/Specialist, patient verbalizes.

DIAGNOSIS

ICD 10 Code	ICD 10 Description
I10	Essential (primary) hypertension
D86.9	Sarcoidosis, unspecified
K74.60	Unspecified cirrhosis of liver
D50.9	Iron deficiency anemia, unspecified
I51.7	Cardiomegaly
E66.3	Overweight
Z68.28	Body mass index [BMI] 28.0-28.9, adult
E11.9	Type 2 diabetes mellitus without complications

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Coding Tips

- When documentation supports history of liver transplant, an additional code should be reported **Z94.4 Liver transplant status**
- Code K70.3 and K71.7 cannot be reported together with K74* category codes, as per Excludes1 note
- Code also, if applicable, viral hepatitis (acute) (chronic) (B15-B19) together with K74* codes

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Q & A

Based on the reviewed coding tips, what additional codes may be assigned along with liver cirrhosis when documentation supports it?

a) History of liver transplant
b) Viral hepatitis specified whether acute or chronic.
c) Both a and b

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Q & A

Based on the reviewed coding tips, what additional codes may be assigned along with liver cirrhosis when documentation supports it?

a) History of liver transplant
b) Viral hepatitis specified whether acute or chronic
c) Both a and b

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Cirrhosis ICD-10-CM Codes

K74.3

- Primary biliary cirrhosis
- Chronic nonsuppurative destructive cholangitis
- Primary biliary cholangitis

K74.4

- Secondary biliary cirrhosis

K74.5

- Biliary cirrhosis, unspecified

K74.6*

- K74.60-Unspecified cirrhosis of liver
- K74.69-Other cirrhosis of liver

K70.3*

- K70.30-Alcoholic cirrhosis of liver without ascites
- K70.31-Alcoholic cirrhosis of liver with ascites

K71.7

- Toxic liver disease with fibrosis and cirrhosis of liver

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Healthfirst Job aids for Providers & Coders

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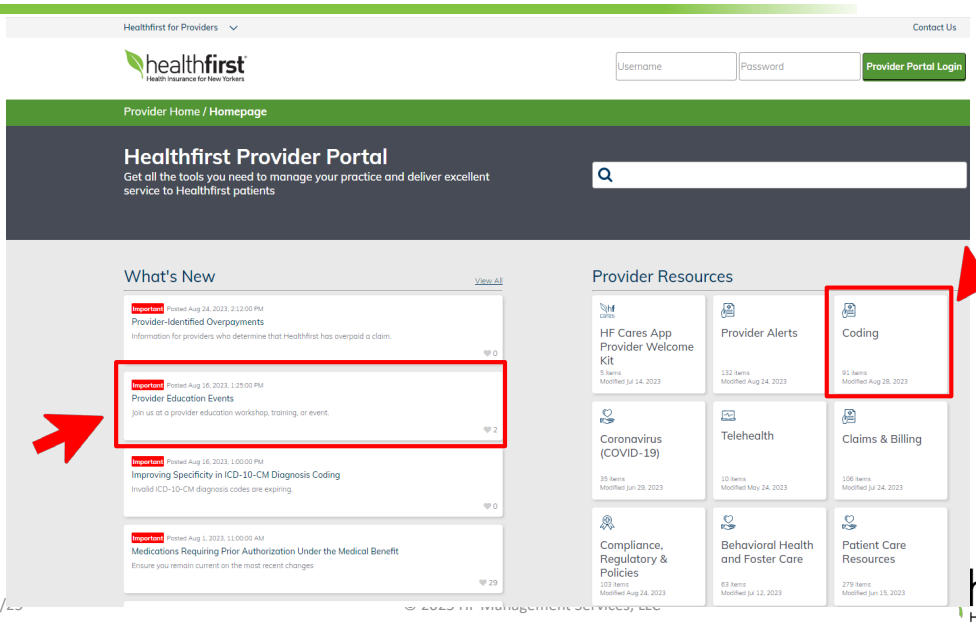
https://hfproviders.org/what-s-new/provider-education-events

Healthfirst Provider Website (HFproviders.org)



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Register for June Provider Education Events

Posted Jun 04, 2024

Together, we can improve patient outcomes. Join us at a provider education workshop, training, or event.

To receive future event invitations, sign up **here**.

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Healthfirst Provider Symposia

2024 Fall Provider Symposium

- Nov 15, 2024, at 8:30am - Register Here

Trainings

On-Demand Professional Education Course:
American Lung Association's Asthma Educator Institute

- On-demand course - Register Here

Continuing Medical Education

Prescription for Long Life Dinner Series

- Details and registration information are **available here**.
- This CME conference series is provided in collaboration with Healthfirst, Chinese American Medical Society (CAMS), CAIPA, Charles B. Wang Community Health Center, and Maimonides

- ✓ Continuing Medical Education
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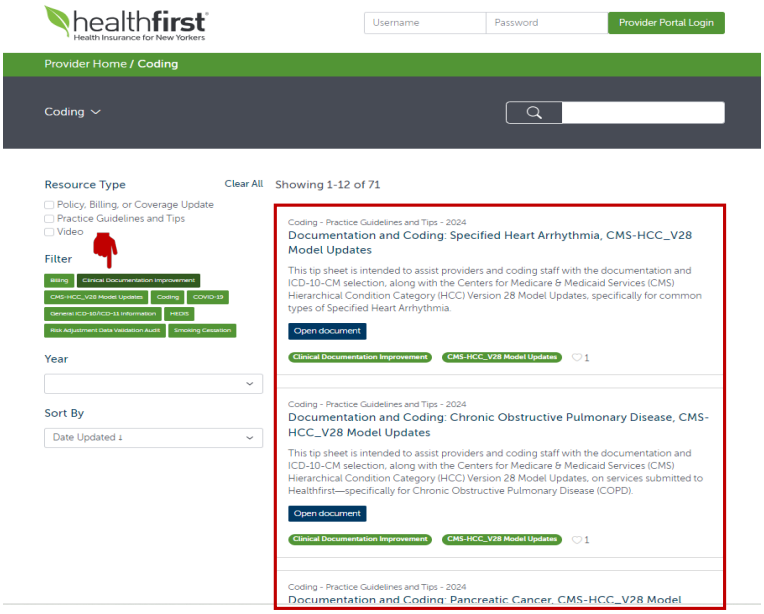

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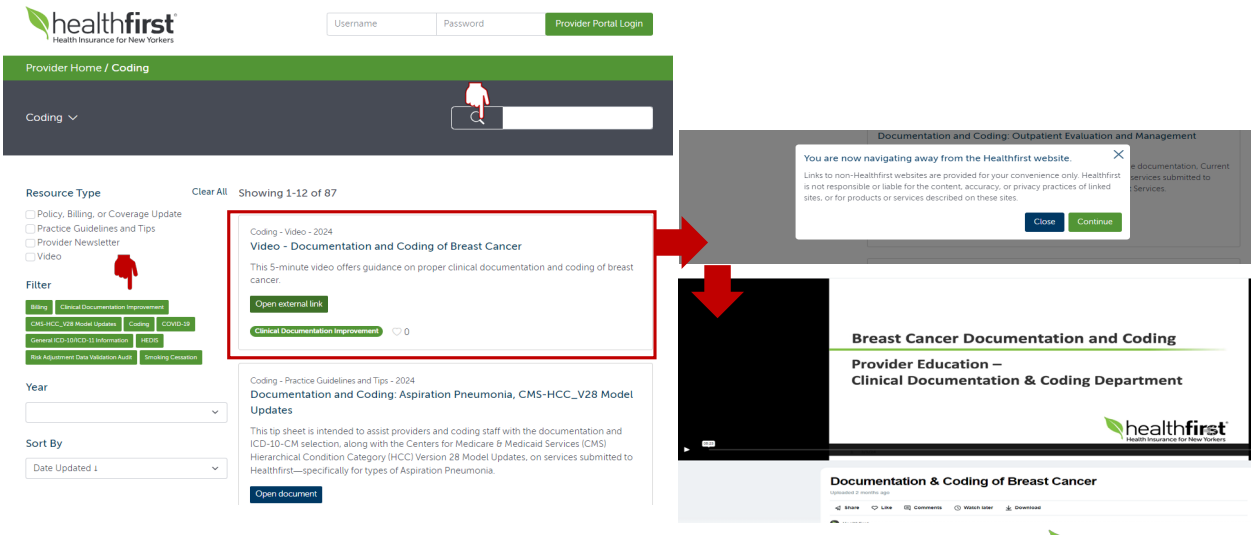

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Questions

- Email any questions or concerns at #Risk_Adjustments_and_clinical_Documentation@healthfirst.org
- The Healthfirst Provider Portal has great resources that can be useful use link below
  - https://hfproviders.org/provider-resources/coding

References:

- 2024-icd-10-cm-coding-guidelines
- AHA Coding Clinic Advisor Homepage | AHA Coding Clinic | AHA Coding Clinic
- Acute Pulmonary Embolism - StatPearls - NCBI Bookshelf
- Hepatitis C: What happens in end-stage liver disease? - Mayo Clinic
- Two Criteria Determine DVT and Venous Emboli Dx - AAPC Knowledge Center
- Guide Your Liver Condition Coding to Clean Claims : ICD-10-CM

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ABOUT HEALTHFIRST

Healthfirst believes that every New Yorker deserves access to the best available healthcare. As one of New York's highest quality not-for-profit health insurers serving close to 2 million New Yorkers, we make this a reality for our members. Founded more than 30 years ago by the leading hospital systems in downstate New York, Healthfirst established a partnership model that enables hospitals, health systems, and physicians in our network to work with us to prioritize health outcomes and to place the needs of our members and community first. We strive to advance health equity so that all individuals, regardless of race, neighborhood, or income, can thrive and live healthy, fulfilling lives. Healthfirst serves members in New York City, on Long Island, and in Westchester, Rockland, Sullivan, and Orange counties, offering market-leading products to suit every life stage. Our offerings include Medicaid plans, Medicare Advantage plans, Long-Term Care plans, Qualified Health plans, and Essential Plans.

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Northwell Health is New York State's largest health care provider and private employer, with 20+ hospitals, 890+ outpatient facilities and more than 18,500 affiliated physicians. We care for over two million people annually in the New York metro area and beyond, thanks to philanthropic support from our communities. Our 85,000 employees — 18,900 nurses and 4,900 employed doctors, including members of Northwell Health Physician Partners — are working to change health care for the better. We're making breakthroughs in medicine at the Feinstein Institutes for Medical Research. We're training the next generation of medical professionals at the visionary Donald and Barbara Zucker School of Medicine at Hofstra/ Northwell and the Hofstra Northwell School of Nursing and Physician Assistant Studies.

Thank you for attending
Session 4: Pulmonary Embolism (PE) and Deep Vein Thrombosis (DVT), Hepatitis & Cirrhosis of the OIG Targeted High Risk Condition Series
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