SCOPE-OK

Southcentral Consortium for Overdose Prevention and Education in Oklahoma

Leading Rural Oklahoma to Improve Lives

Understanding the Complexities of Behavioral Health Coding Presented by CSI Companies

What are RCORP and SCOPE-OK?

- The Rural Communities Opioid Response Program (**RCORP)** is a $298 million, multi-year grant initiative supported by Health Resources and Services Administration (HRSA) to address barriers to access in rural communities related to substance use disorder (SUD), particularly Opioid Use Disorder (OUD)
- The Southcentral Consortium for Overdose Prevention and Education in Oklahoma (**SCOPE-OK**) will work to address barriers to the prevention, treatment, and recovery of opioid and other substance disorders.

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SCOPE-OK Consortium

- **SCOPE-OK** meets the 2nd Month each quarter (February, May, August, November)– Ardmore Public Library 10 AM-12 PM
- Members include:
  - Groups focused on rural, preventative, and/or public health
  - Healthcare providers from all settings of care
  - Educators and school system representatives
  - Organizations involved with the prevention, treatment, and recovery of substance use
  - Persons directly impacted by substance use (persons in recovery, impacted family members, persons who use drugs, etc.)

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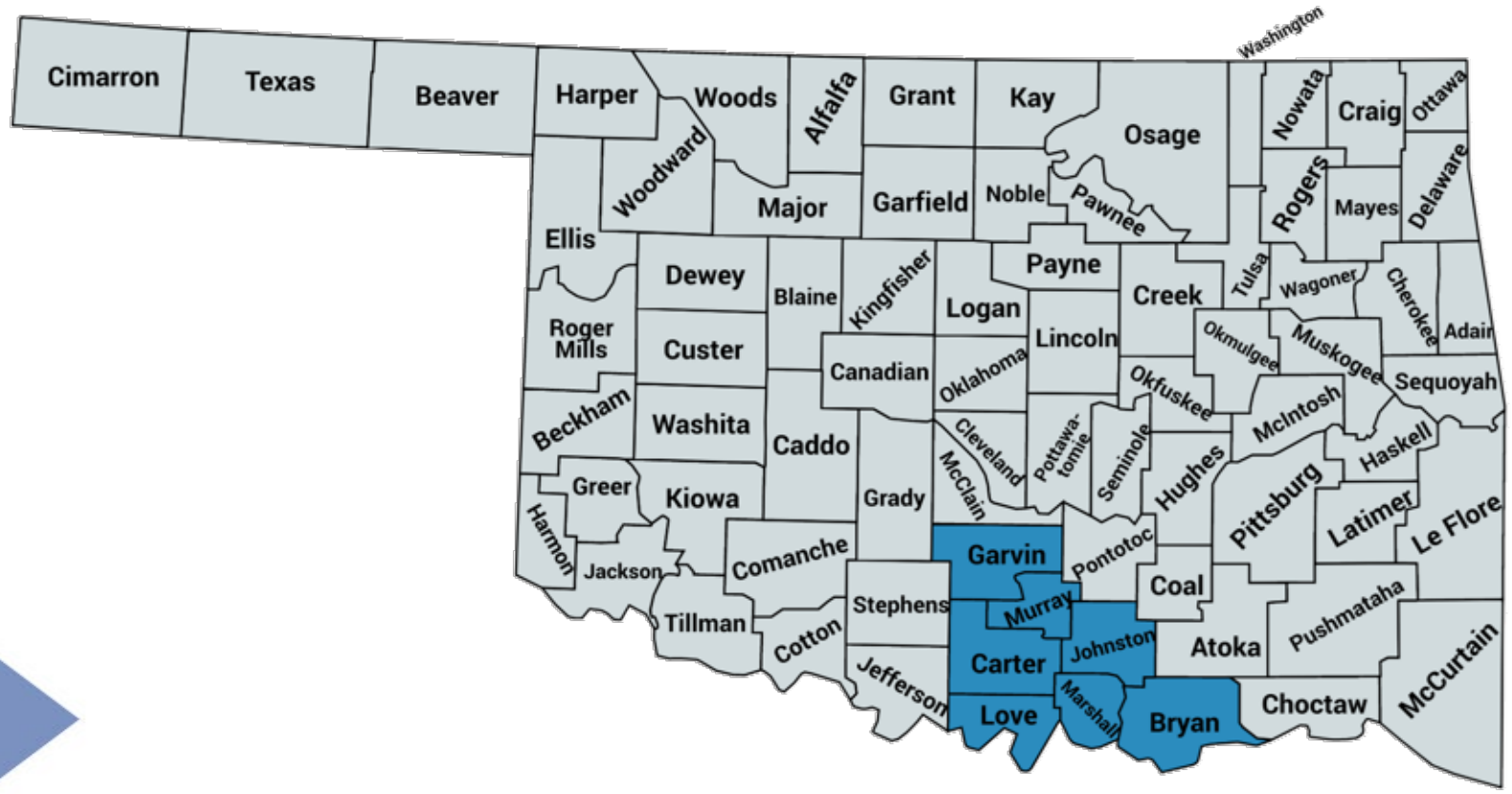
SCOPE-OK Service Area

- Targeting 7 counties in south central/ I-35 corridor region
  - Bryan
  - Carter
  - Garvin
  - Johnston
  - Love
  - Marshall
  - Murray



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SCOPE-OK Can Help!

Training

Our certified trainers can train anyone on naloxone use or stigma of substance use disorders.

Community Collaboration

We can collaborate with your organization to work on your goals related to prevention, treatment, and recovery.

Technical Assistance

Let us assist you in implementing or optimizing your technology to create better care coordination opportunities.

Education Events

We host a variety of events focused on a variety of topics including sensitivity of results, prescribing guidelines, telehealth, value-based care models, and more .

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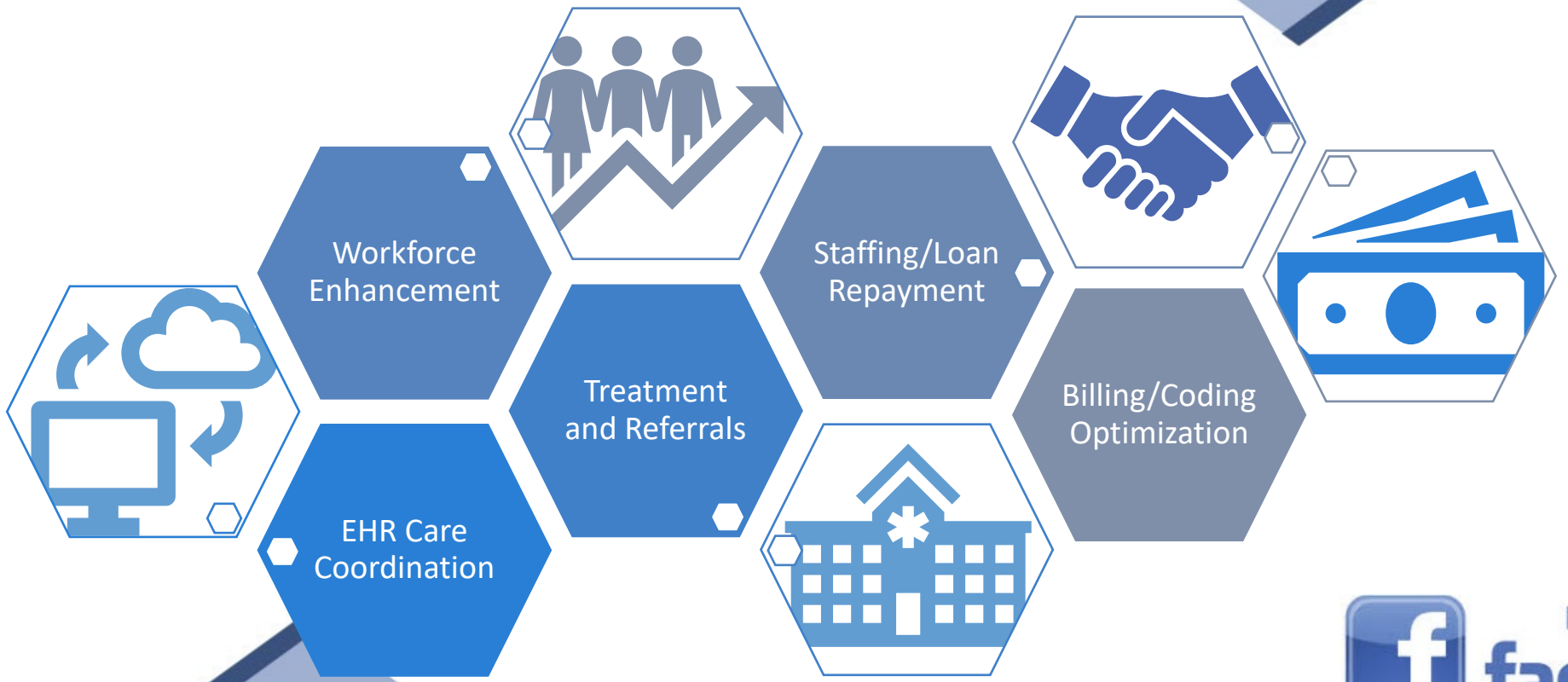

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Valentina Gallegos, BA, CPC, CRC

Valentina holds a Bachelor of Arts degree from the University of Colorado and Certified Professional Coder (CPC) and Certified Risk Adjustment Coder (CRC) certifications from the American Academy of Professional Coders (AAPC), she possesses a strong foundation in healthcare management and a deep understanding of coding guidelines and regulations. She began her career in the medical field at Kaiser Permanente working in the claims department with ICD-9 codes. She progressed her career in the ACO world, working side by side with Physicians and their staff providing education on HCC coding and closing gaps in HEDIS measures! Today, as the Director of Quality and Education at CSI Companies, Valentina is proud to collaborate with healthcare partners to meet integral KPI's in both the Risk Adjustment and Professional coding realm!

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Understanding the Complexities of Behavioral Health Coding

Objectives

- Recognize behavioral health coding guidelines
- Identify key documentation requirements
- Apply concepts to case scenarios

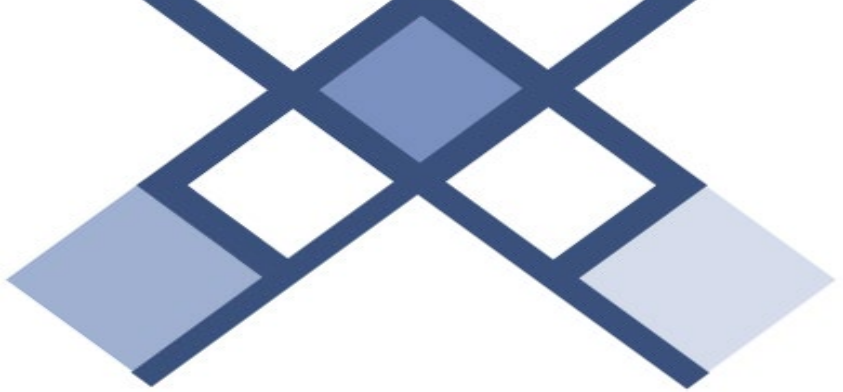
ICD-10-CM Official Coding Guidelines

- Chapter 5: Mental, Behavioral and Neurodevelopmental disorders
- All codes begin with alphabetic character “F”
  - F01-F99

ICD-10-CM Official Coding Guidelines

- Pain disorders related to psychological factors
  - Assign code F45.41—when the pain is *exclusively related to* psychological disorders.
  - Assign code F45.42—for pain disorder *with related* psychological factors.
    - ***Also assign*** a code from category G89 if there is documentation of a psychological component for a patient with acute or chronic pain.

Example



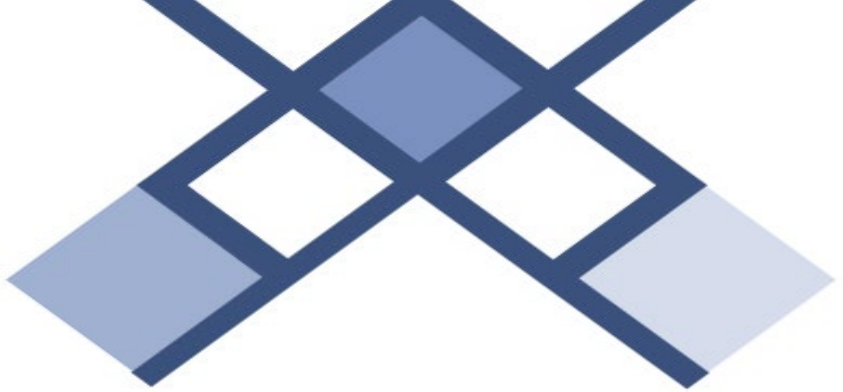
46 y/o patient presents with complaints of panic attacks three times last week. Patient diagnosed with depression, currently taking Lexapro 20 mg daily. Patient states that she has acute abdominal pain from a ruptured appendix. Surgery to remove the appendix was three weeks ago. Patient continues to complain of pain, even though the surgical site appears to be healing well and all tests for infection are negative.

- Diagnoses:
  - Major depressive disorder, single episode, with mild agitation related to abdominal pain and her inability to cope with pain levels. Patient is to continue Lexapro, avoid caffeine and alcohol. Increase physical activity.
  - F32.0—major depressive disorder, single episode, mild
  - F45.42—pain disorder with related psychological factors
  - G89.18—other acute postprocedural pain

ICD-10-CM Official Coding Guidelines

- Mental and Behavioral disorders due to psychoactive substance use
  - In Remission
    - To code a disorder in remission requires the provider's clinical judgement and are assigned based on provider documentation.
    - Mild substance use disorders are coded to substance abuse in remission
    - Moderate and severe substance use disorders are coded to substance dependence in remission

Example



58 y/o male presents to the clinic today in follow up. The patient began drinking during the COVID-19 pandemic because of the decline of his small business and subsequent financial struggles. Six months ago, his family had an intervention with him, and he began to participate in AA meetings. He has not had a drink in six months. He reports no further problems at this time.

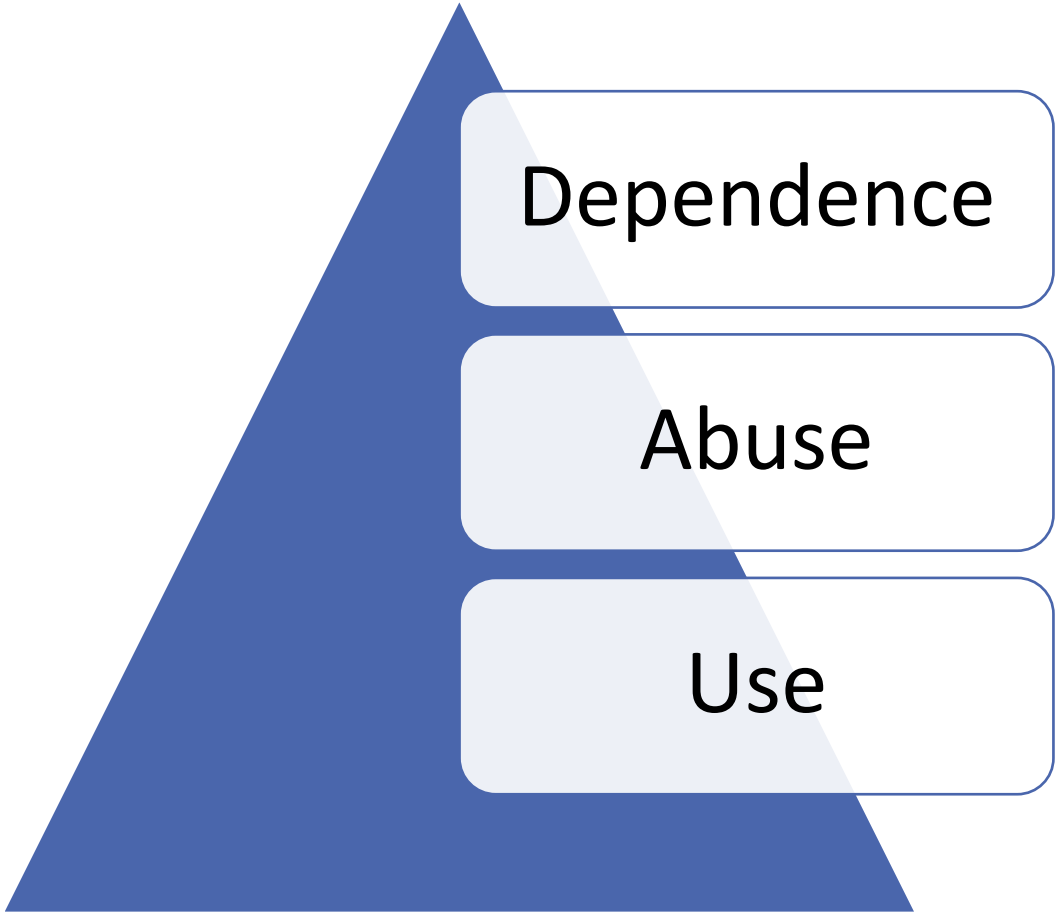
Diagnosis: Mild alcohol use disorder, in remission.

F10.11 Alcohol abuse, in remission.

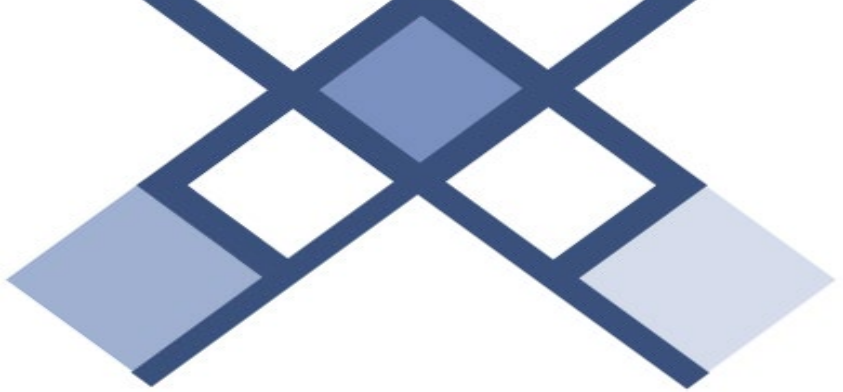
ICD-10-CM Official Coding Guidelines

- Use, Abuse and Dependence
  - Only one code is needed to identify the pattern of use based on hierarchy.
    - If both use and abuse are documented—assign the code for abuse.
    - If both abuse and dependence are documented –assign the code for dependence.
    - If both use and dependence are documented –assign the code for dependence.
    - If use, abuse and dependence are documented—assign the code for dependence.
    - Code to the highest level of use documented.
    - BE CAREFUL when using “unspecified” as the pattern of use.

Use, Abuse and Dependence



Use, Abuse and Dependence

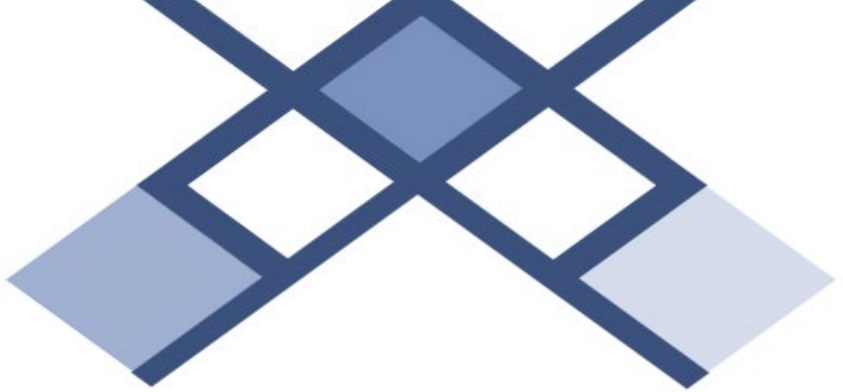


- **Use**—typically defined as recreational use or medicinal use
- **Abuse**—defined as using the substance in a quantity or frequency that it creates life problems such as inability to hold down a job, social or family issue. It can put the patient at a physical risk.
- **Dependence**—also defined as addiction, is a compulsive physical or psychological reliance to such a degree that stopping creates physical side effects of withdrawal.

Remission, Intoxication, or Withc

- **Remission**—patient is not currently using the substance
- **Intoxication**—patient is drunk, high or under the influence at the time of the encounter
- **Withdrawal**—patient is actively having signs or symptoms of withdrawal.

Example



- A 29-year male patient presents with a 10-year history of cannabis use. The patient states that he cannot gain employment because he cannot pass the drug screen requirement for many jobs. He has attempted to stop using cannabis in the past week and found himself with increased cravings and extremely irritability.
- Diagnosis: Cannabis use disorder, moderate

  F12.10

ICD-10-CM Official Coding Guide

- Medical Conditions Due to Psychoactive Substance Use, Abuse and Dependence
  - Medical conditions are not classified as substance-induced disorders.
  - A diagnostic code for the medical condition as well as a secondary code for the substance use, abuse or dependence code is needed to accurately describe the patient's condition.

Example

- A 24-year-old female presents to the clinic for alcoholic pancreatitis due to alcohol dependence. Patient has been drinking since her early teens and states she drinks 1/5 of vodka daily. She was diagnosed with acute pancreatitis on a recent ED visit. She is seen in follow up for medication management today.

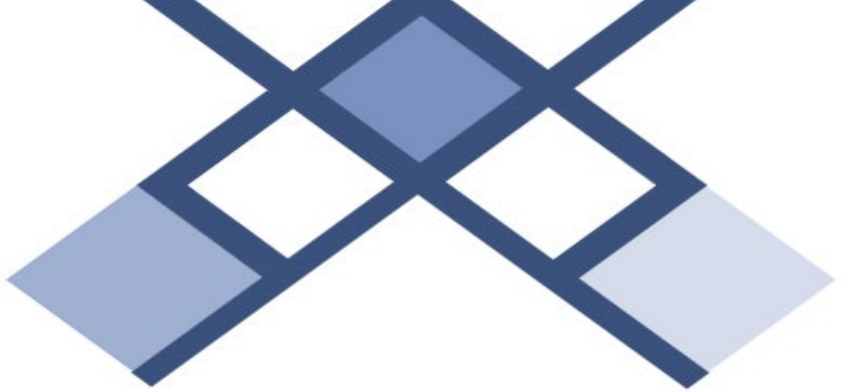
Diagnosis: Acute alcoholic pancreatitis, alcohol dependence

- K85.20, alcohol induced acute pancreatitis without necrosis or infection
- F10.20, alcohol dependence uncomplicated.

ICD-10-CM Official Coding Guidelines

- Dementia
  - Dementia is classified based on etiology and severity.
  - Severity is defined as unspecified, mild, moderate, or severe.
  - Appropriate selection of severity is based provider documentation.
  - *Use of unspecified should be used as a last resort.*
  - If a patient is admitted at one severity level and progresses to a higher level, assign only one code for the highest severity level.

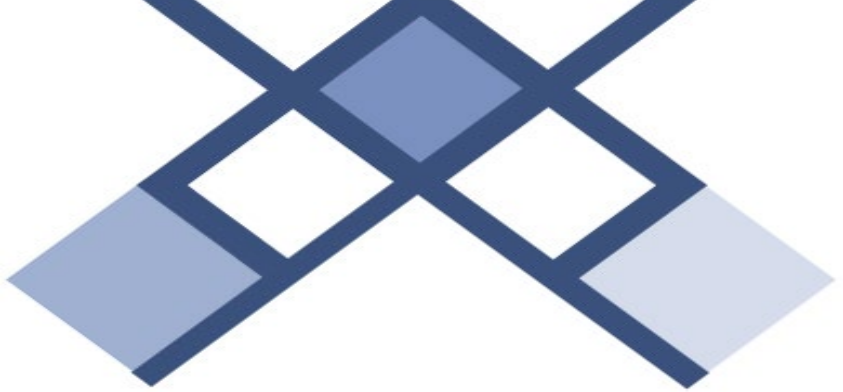
Mild, Moderate and Severe



- Mild Dementia—memory loss, confusion, trouble handling money, poor judgement, loss of spontaneity, mood and personality changes.
- Moderate Dementia—All of the issues of Mild Dementia plus repetitive statements or movements, occasional muscle twitches, restlessness, agitation, anxiety, tearfulness, hallucinations, delusions, paranoia.
- Severe Dementia—All of the issues of Mild and Moderate Dementia plus weight loss, seizures, increased sleep, groaning, moaning, lack of bladder and bowel control.

****Coder cannot assume severity—physician must document severity*

Example



- A 67-year-old male presents for a follow up visit. He retired at age 62 and has remained active until last year when he was diagnosed with early onset Alzheimer's. He lives with his son and his family. He presents today with his son who reports instances of hallucinations and increased paranoia.

Diagnosis: Early onset Alzheimer's disease, Moderate dementia with psychotic disturbance, wandering.

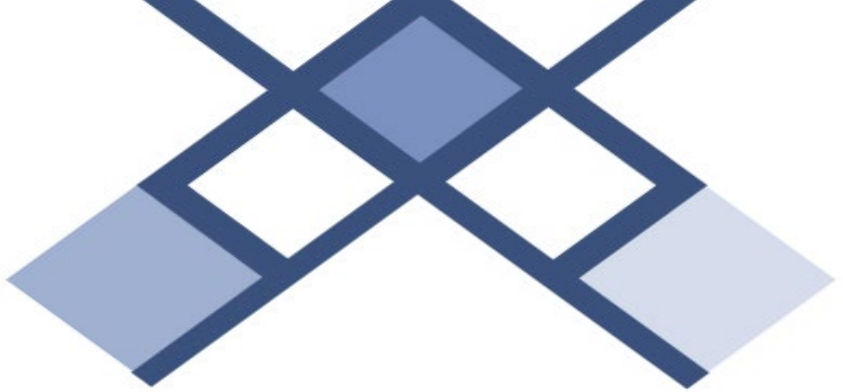
G30.0, Alzheimer's disease with early onset

F02.B2, Dementia in other disease, moderate, with psychotic disturbance

Vascular Dementia

- Also called “multi-infarct” dementia
- Normally occurs when a patient has vascular damage following a stroke.
- ICD-10-CM *combines* the disease with the behavior
  - F01.50—Vascular dementia without behavioral disturbance
  - F01.51—Vascular dementia with behavioral disturbance

Parkinson's Disease

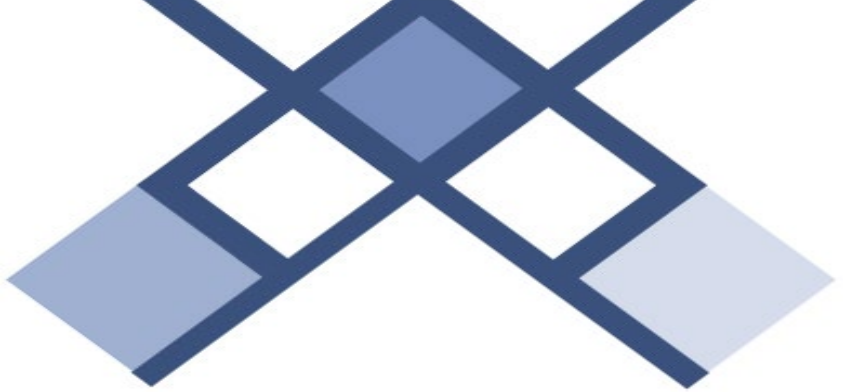


- Patient's suffering from Parkinson's disease may develop signs of dementia in the latter stages of the disease process.
- To correctly code Parkinson's disease with dementia the physician should specify with or without behavioral disturbances; thus requiring two codes
  - G20.A1, F02.80--Parkinson's Disease without dyskinesia or fluctuations; without behavioral disturbances
  - G20.A1, F02.81—Parkinson's Disease without dyskinesia or fluctuations; with behavioral disturbance.

Delirium and Wandering

- To further describe dementia physicians should document these potential complications.
- **Delirium**--Although delirium can result in delusions or hallucinations, it is frequently the result of an infection (such as UTI). Physician should specify the cause of the delirium.
  - F05—Delirium due to known physiological condition.
- **Wandering**—A specific symptom of dementia that can be added as an additional secondary code when documented by the physician. Approximately 60% of patients with dementia will wander at some point.
  - Z91.83—Wandering in diseases classified elsewhere.

Memory Loss



- A certain amount of memory loss is a normal part of aging and is a separate disease process.
- ICD-10-CM determines memory loss to be equal to or significantly more than patients of the same age.
  - For patients with memory loss/forgetfulness **equal** to those of other in the same age group assign code R41.81—age-related cognitive decline.
  - For patients experiencing **more** memory loss/forgetfulness the physician should document *mild cognitive dementia*. Assign code G31.84, mild cognitive impairment.

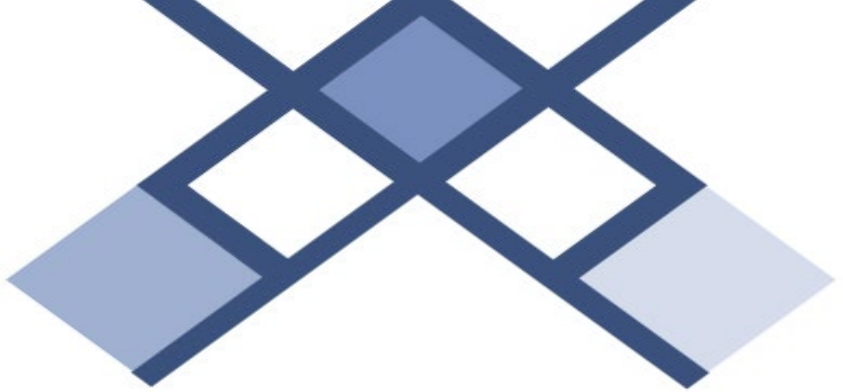
Provider Documentation Tips

- Specify
  - Substance name
  - Type of disorder: use, abuse, dependence, withdrawal
  - Severity: mild, moderate, or severe
  - Status: current, in remission (partial or full)

Provide Documentation Tips

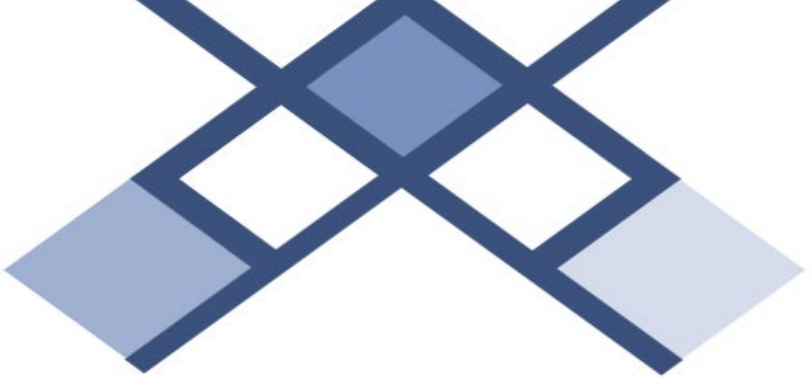
- Complications
  - Document the relationship between the substance disorder and any associated physical, mental, or behavioral disorders such as:
    - Intoxication or withdrawal
    - Delirium or perceptual disturbance
    - Mood, anxiety levels
    - Loss of sleep
    - Depression or psychotic episodes
    - Wandering

Provider Documentation Tips



- Treatment Plan
  - Include the diagnosis plus:
    - Medication (new, adjusted, stopped)
    - Psychotherapy (new, adjusted, stopped)
    - Any refusual of treatment
    - Any noncompliance with medication or therapy
    - Social Determinants of Health
      - Homelessness
      - Abuse/Neglect
      - Availability of resources
      - Access to education or employment

Case Scenario #1



A 19-year-old male presents to the clinic stating he is “sees bugs on his arms.” Patient admits to huffing glue on a regular basis, at least once a day. He has multiple open wounds on both forearms where he has tried to “scratch the bugs off.” A couple of the wounds appear to be infected.

History—New patient—detailed

Exam—full review of systems

Diagnosis: Medical decision low complexity

Glue abuse, with psychosis and hallucinations –patient encouraged to seek outpatient counseling for huffing abuse. Referred patient to XYC Counseling Services.

Open wounds, bilateral forearms. Wounds cleaned, no stitches needed, treated with antibiotic cream and bandages. Largest wounds measure 3 and 4 cm long.

99203—New patient, detailed history, detailed exam, low complexity, time spent 31 minutes. (Because this is a new patient all three components must be met to assign the appropriate E/M code)

F18.151—Inhalant abuse with inhalant-induces psychotic disorder with hallucinations.

S51.811A—Laceration w/o foreign body of right forearm, initial encounter

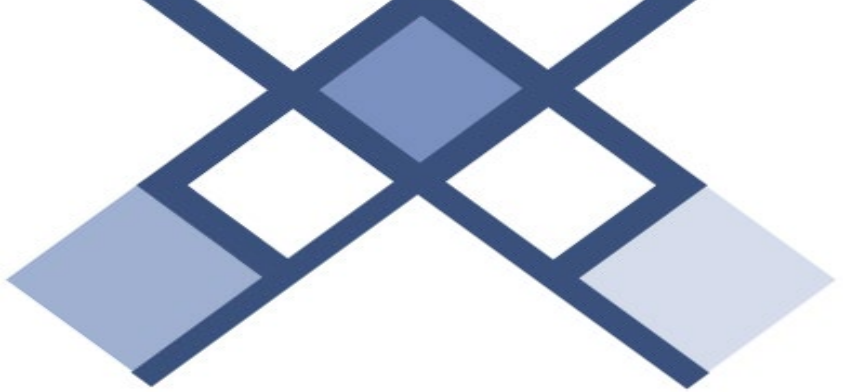
S51.812.A—Laceration w/o foreign body of left forearm, initial encounter

Case Scenario #2

Sheila Cross is a 68-year-old female well known to me. She has a known severe dementia due to late onset of Alzheimer's disease and functional quadriplegia is seen in the clinic today due to increase agitation and combativeness over the past week. She lives with her daughter and her family.

- PMH: Significant for hypertension, T2DM, Severe Dementia, Alzheimer's, Quadraplegia.
- Medications: Lisinopril 10 mg daily, Metformin 500 mg bid, Rexulti 0.5 mg daily.
- Exam—Detail
- MDM—Moderate Complexity
- Assessment/Plan:
  - Alzheimer's with severe dementia, continue Rexulti adjusted to 1.0 mg daily
  - Functional Quadraplegia, continue with home health therapy twice a week. Daughter to perform exercises three days a week.
  - Hypertension, continue to Lisinopril.
  - T2DM, continue Metformin and healthy diet.

Case Scenario #2 (continued)



- 99214—Expanded problem focused, detailed exam, moderate complexity.
- G30.1—Alzheimer's disease with late onset
- F02.C11—Dementia in other diseases classified elsewhere, severe, with agitation.
- R53.2—Functional quadriplegia
- I10—Hypertension
- E11.9—Type 2 Diabetes mellitus without complications

Case Scenario #3

Kathryn Jones is a 13-year-old female presenting as an established patient today. Her mother states that she has a six-month history of increased agitation at school. Kathryn has difficulty paying attention in class and admits to hyperactivity. Patient describes her symptoms as mild, but mother states they are moderate. The patient admits that her hyperactivity has had a direct impact at school and that her grades have fallen. The patient states that the increased demands of homework and social situations "stress her out." Patient does admit that she has no improvement since her last visit and claims to be "worse than ever before."

Exam: Limited

ROS: Patient admits to inattention, slightly depressed mood.

PMH: Asthma, uses an inhaler prn.

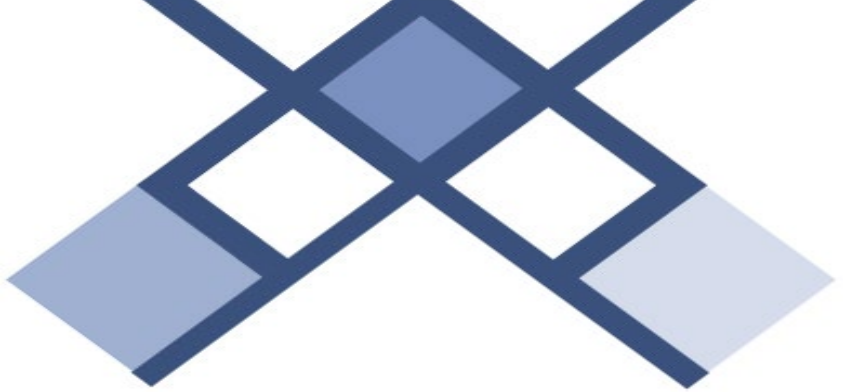
Vitals: HR 97 BP 120/73, WT 135 lbs, HT 5'7"

Psychiatric: Normal speech, normal thought process, No suicidal ideations, denies hallucinations, AAO to time and place, limited attention span.

Case Scenario #2 (continued)

- MDM: Limited, minimal complexity, moderate medication management, overall low complexity.
- Assessment/Plan
  - Attention Deficit Disorder with Hyperactivity, inattention type; start Lisdexamfetamine 20 mg each morning.
  - Asthma—continue inhaler as needed.
  - Social phobia—referred to a pediatric counselor.

Case Scenario #3 (continued)



- EM level 99213
- F90.0—Attention-deficit hyperactivity disorder, predominantly inattentive type.
- F40.10—Social phobia, unspecified
- J45.909—Unspecified asthma, complicated

Case Scenario #3 Risk Adjusted

Patient A	Risk Adjusted	Patient B	Risk Adjusted
F90.0 (HCC)	0.191	F90.0 (HCC)	0.191
F40.10 (HCC)	0.118	99213	1.3
J45.909 (CC,HCC)	0.260		
99213	1.3		
Total	**1.869**		**1.491**

Case Scenario #4

Joe Smith, a 55-year-old male presents in follow up for alcoholic gastritis. Joe has a 25-year history of alcohol usage, drinking 1/5 of whiskey a day or more. He is currently receiving active treatment for his alcohol dependence. On his last visit he was prescribed Tagamet for his gastritis.

PMH: History of cocaine dependence, quit using five years ago. Currently smokes 1 pack of cigarettes per day. Hypertension.

MDM: Low level, 25 minutes 99213

A/P:

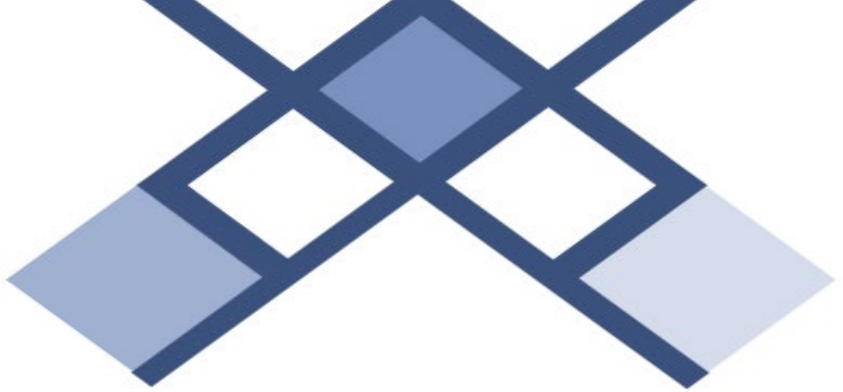
Chronic alcoholic gastritis, continue Tagament

Hypertension, continue Lisinopril

Alcohol Dependence, continue active treatment

Smoker—provided smoking cessation information

Case Scenario #4



- 99213
- F10.20—Alcohol dependence, uncomplicated
- K29.20—Alcoholic gastritis without bleeding
- I10—Essential primary hypertension
- F17.210—Nicotine dependence, cigarettes, uncomplicated
- F14.21—Cocaine dependence, in remission (there is no code for a “history of cocaine dependence” therefore, in remission is the appropriate clarification.

Case Scenario #4 Risk Adjusted

Patient A	Risk Adjusted	Patient B	Risk Adjusted
99213	1.3	99213	1.3
F10.20	0.00	F10.20	0.00
K29.20	0.00	K29.20	0.00
I10	0.128		
F17.210	0.00		
F14.21	0.279		
Total	1.70		1.30

Case Scenario #5

Ms. Johnson is a 62-year-old woman who is well known to me. I have been treating her for anxiety and depression since 2001. On today's visit she appears to be increasingly depressed and state she stays in bed on her days off, has to "make herself" go to work each day, and has stopped her social activities. The patient reports bouts of crying, insomnia, recent 20-pound weight loss, lack of concentration, and suicidal ideation. She states that she has auditory hallucinations, thinking that her husband is calling for her when he is not in the house.

Current medications include Wellbutrin 150 mg daily, Lexapro 20 mg daily, Xanax 1 mg tid, and Combivent inhaler.

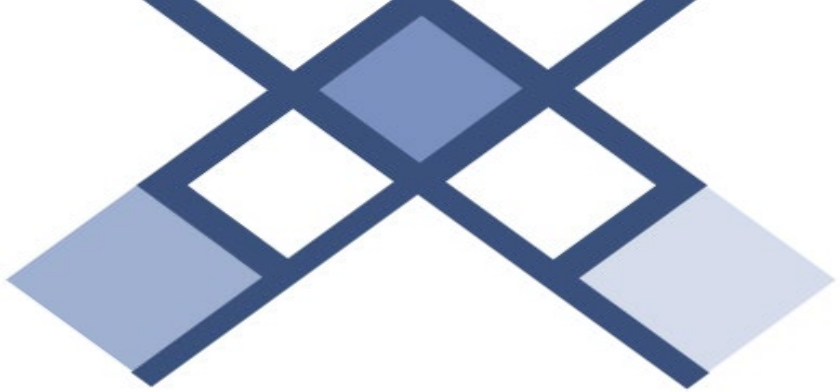
MDM: Moderate decision making

Case Scenario #5

Assessment/Plan:

1. Major depressive disorder, recurrent, severe with hallucinations. Continue Wellbutrin and Lexapro
2. Suicidal ideations
3. Panic disorder, continue Xanax
4. Referred patient to a psychiatrist for further counseling
5. Provided husband with suicidal precautions information
6. Encouraged patient and husband to seek immediate care if the patient acts, or says she will act on suicide ideations

Case Scenario #5



99214

F33.3—major depressive disorder, recurrent, severe with psychotic symptoms

R44.0—Auditory hallucinations

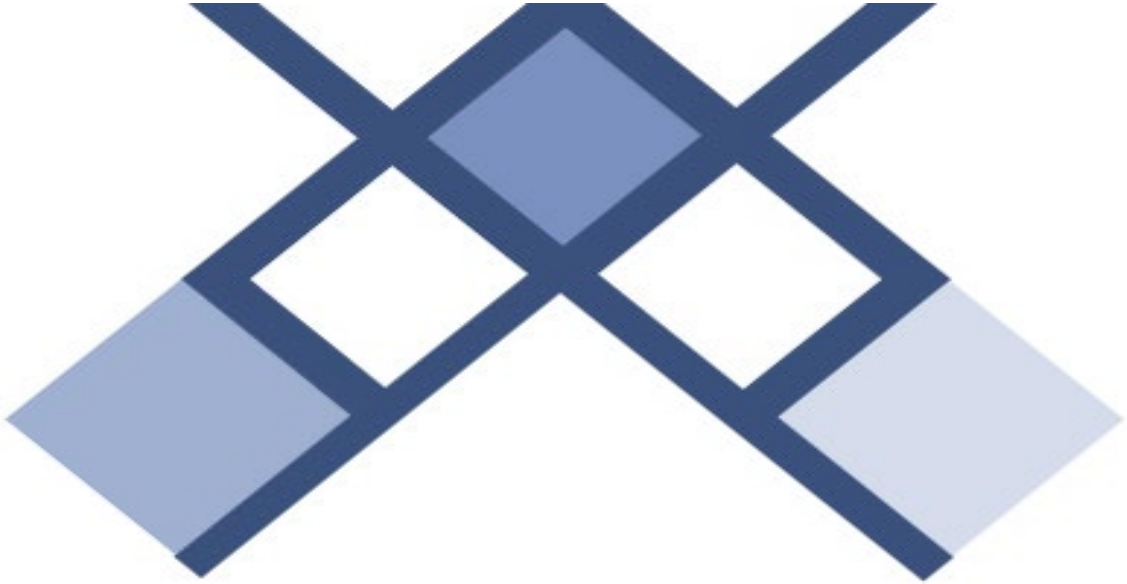
R45.851—Suicidal ideations

F41.0—Panic disorder (episodic parozysmal anxiety)

Case Scenario #5 Risk Adjusted

Patient A	Risk Adjusted	Patient B	Risk Adjusted
99214	1.40	99214	1.40
F33.3 CC/HCC	0.832	F33.3	0.832
R44.0 CC	0.00	F41.0	
R45.851 CC	0.00		
F41.0 HCC	0.110		
Total	2.342		2.232

Questions??



Mission of OFMQ

OFMQ is a not-for-profit, consulting company dedicated to advancing healthcare quality. Since 1972, we've been a trusted resource through collaborative partnerships and hands-on support to healthcare communities.

SCOPE-OK
Southcentral Consortium for Overdose Prevention and Education in Oklahoma

Our Organization

IN EXISTENCE SINCE 1972

NOT-FOR-PROFIT

HEALTHCARE RESOURCE

BROAD ENGAGEMENT – HOSPITALS, CLINICS, LTC, ETC.

TEAMS OF EXPERTS

Our Experience

QIO- 45 Years

Regional Extension Center- 6 Years

Hospital Quality Measures- 16 Years

Analytics for Quality Programs- 23 Years

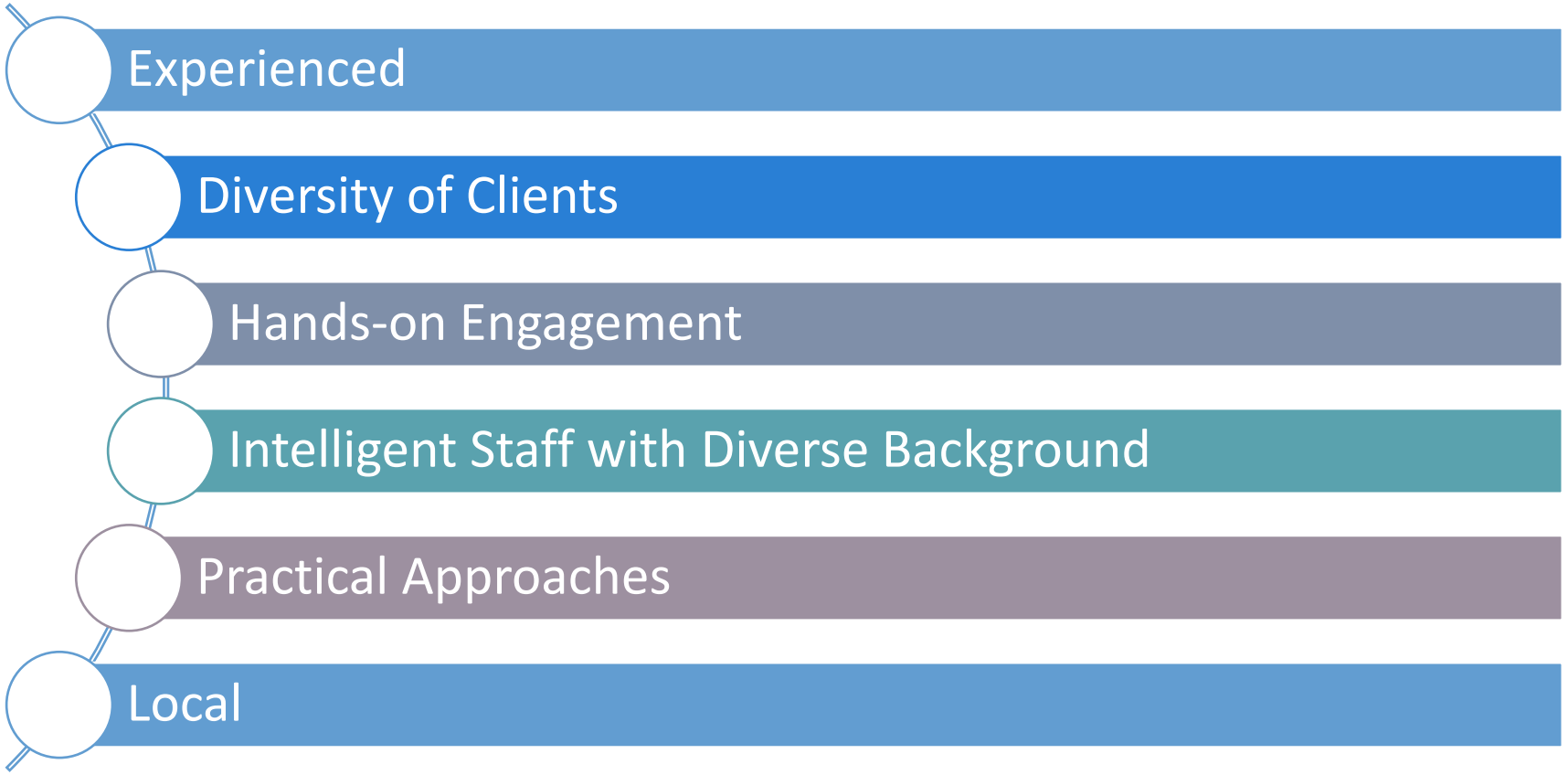
Value Based Payment Programs-11 years

Case Review- 47 Years

HIPAA Solution- 8 Years

Long-Term Care Quality Improvement- 20 years

Our Difference



He
(HIT)

HIT Quality Improvement

Quality Improvement Expertise

- Care Transitions and Referral Management
- Opioid Misuse and Reduction
- Diabetes Prevention Program
- Public Health Emergencies
  - Registry Connections
  - Reporting Requirements and Guidance
  - COVID 19 Educational Training and Testing Implementation
- Dementia Care
- Chronic Disease Management
- Food Insecurity
- Project ECHO

HIT Quality Improvement

Ambulatory Value-based Care Consulting

- Accountable Care Organizations
- Merit-based Incentive Payment System
- Patient Centered Medical Home

Hospital Reporting

- The Joint Commission
- Inpatient Quality Reporting
- Outpatient Quality Reporting
- Promoting Interoperability

Long-Term Care

- Quality Improvement

Risk Management & Security Services

Risk Management Overview

INFOSEC IQ

Educate & empower employees

Educate and engage your workforce

- Deliver memorable campaigns with industry-leading content & assessments
- 350+ training modules in 34+ languages

Inspire better cybersecurity habits

- Educate year-round and serve in-the-moment training for employees who need it most
- 1000+ phishing simulation templates with multiple attack types

Reduce security incidents

- Avoid attacks and quickly respond to employee-reported events
- Automated reporting button, reports and analytics

Build a culture of security

- Go beyond awareness with a culture built to keep your organization secure
- Program resources — posters, infographics, kits and more

RCORP Resources For You

- The RCORP-TA portal is publicly available and has information about programs, grantees, and various trainings and resources available.
- https://www.rcorp-ta.org/

SCOPE-OK

Southcentral Consortium for Overdose Prevention and Education in Oklahoma

Leading Rural Oklahoma to Improve Lives

Thank You for Attending!

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