OFFICIAL STUDY GUIDE

CRC™

CERTIFIED RISK ADJUSTMENT

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Regarding HCPCS Level II
HCPCS Level II codes and guidelines discussed in this book are current as of press time. The 2021 code set for HCPCS Level II were unavailable when published.
About the Author

Brian Boyce has over 25 years of healthcare experience. He started his career in Aeromedical Evacuation (flight nursing) in the US Air Force. He has over 15 years of healthcare management experience and has spent the last 5 years with a focus on risk adjustment (diagnosis coding). He is regularly contacted by coders from virtually every big player in the risk adjustment market for his opinions, advice and expertise. He is a PMCC instructor and ICD-10-CM trainer. His company ionHealthcare offers PMCC courses, CEUs, and consulting specializing in coding operations, practice management and risk adjustment. Brian is trained in Six Sigma, and has many certifications to include a Certificate in Clinical Bioethics from Georgetown. Brian holds a Bachelors of Science in Health Sciences with a concentration in Health Administration from Old Dominion University.

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All coders have an original coding instructor who initiates him or her to the coding profession. The author would like to also thank Jaci C. Johnson, CPC, CPC-H, CPMA, CEMC, and CPC-I of Practice Integrity. Jaci was not only a tremendous influence on the understanding of coding practice, but has been a true mentor and a reliable professional resource over the years from my local chapter. Thank you for your guidance, support, wisdom, and friendship.
## Contents

### Chapter 1
**The Business of Medicine** ................................................................. 1
- 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** ...................................... 13
- Introduction .................................................................................. 13
- Medical Terminology ................................................................... 13
- Integumentary System ................................................................... 16
- Musculoskeletal System ................................................................. 18
- Cardiovascular System ................................................................. 20
- Lymphatic System ....................................................................... 24
- Respiratory System (Pulmonary System) ....................................... 26
- Digestive System ......................................................................... 27
- Urinary System ............................................................................ 28
- Reproductive Systems .................................................................. 29
- Nervous System .......................................................................... 29
- Endocrine System ....................................................................... 30
- Hematologic (Hemic) System ......................................................... 30
- Immune System .......................................................................... 31

### Chapter 3
**Introduction to ICD-10-CM** ............................................................... 35
- Introduction .................................................................................. 35
- Overview of ICD-10-CM Layout ..................................................... 35
- Steps to Look Up a Diagnosis Code ............................................... 39
Contents

Neuropathy ................................................................. 157
Pneumonia ................................................................. 158
Pulmonary Embolism .................................................. 158
Rheumatoid Arthritis ................................................... 160
Substance abuse ......................................................... 161
Ulcers & Wounds ....................................................... 162
Varicose Veins .......................................................... 164
Vertebral Fractures ..................................................... 164

End of Chapter Questions—Answers and Rationales ................. 175
Practice Examination .................................................. 191
Practice Examination—Answers and Rationales .................... 207
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 (e.g., 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 (e.g., 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.
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
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<tr>
<td>APC</td>
<td>Ambulatory Payment Classification</td>
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<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
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<td>ASC</td>
<td>Ambulatory Surgical Centers</td>
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<td>CF</td>
<td>Conversion Factor</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CPC*</td>
<td>Certified Professional Coder</td>
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<td>CPT*</td>
<td>Current Procedural Terminology</td>
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<td>DRG</td>
<td>Diagnosis Related Group</td>
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<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>E/M or E&amp;M</td>
<td>Evaluation and Management</td>
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<td>GPCI</td>
<td>Geographic Practice Cost Index</td>
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<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<td>HHS</td>
<td>Department of Health &amp; Human Services</td>
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<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>ICD-10-CM</td>
<td>International Classification of Disease, 10th Revision Clinical Modification</td>
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<tr>
<td>LCD</td>
<td>Local Coverage Determinations</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
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<tr>
<td>MP</td>
<td>Malpractice</td>
</tr>
<tr>
<td>MS-DRG</td>
<td>Medicare Severity—Diagnosis Related Group</td>
</tr>
<tr>
<td>NCD</td>
<td>National Coverage Determination</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>OCR</td>
<td>Office for Civil Rights</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<tr>
<td>PA</td>
<td>Physician Assistant</td>
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<tr>
<td>PE</td>
<td>Physician Expense</td>
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<tr>
<td>PFS</td>
<td>Physician Fee Schedule</td>
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<td>PHI</td>
<td>Protected Health Information</td>
</tr>
<tr>
<td>PLI</td>
<td>Professional Liability Insurance</td>
</tr>
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</table>
Blood Vessels

Vessels—Arterial Circulation

Source: By LadyofHats, Mariana Ruiz Villarreal [Public domain], via Wikimedia Commons
Reproductive Systems
The organs of the reproductive system differ greatly between male and female. Each produce a 23-chromosome gamete; males produce sperm and females produce eggs. Reproduction is achieved when the two gametes, one egg and one sperm, unite and, through a process called meiosis, form a zygote. The female houses, feeds, and protects the growing fetus through the gestational period.

Both the male and female reproductive organs include external and internal genitalia.

Male Genitalia
External genitalia for the male include the testes, epididymis, scrotum, and penis. Internal organs for the male genital system include the prostate gland, seminal vesicle, and Cowper’s glands. The system of tubes and ducts that sperm travel through to leave the body is comprised of the vas deferens, ejaculatory duct, and the urethra.

Female Genitalia
External genitalia for the female includes the vulva, labia majora and minora, clitoris, external opening of the vagina (introitus), opening of the urethra (urinary meatus), Skene’s glands (found on either side of the urinary meatus), and Bartholin’s glands (found on either side of the introitus). Internal organs for the female genital system include the vagina, uterus, two fallopian tubes, and two ovaries.

Nervous System
The nervous system functions as both the central operator and central intelligence for the body. It regulates bodily functions, provides for an internal method of communication between the brain and other organs as well as between the organism and the environment. The brain and spinal cord are the components of the central nervous system (CNS). The peripheral nervous system (PNS) includes the cranial and spinal nerves. The CNS is the command center and the PNS serves as the communication lines that link all parts of the body to the CNS. Injuries to the nervous system may result in paralysis (paraplegia, quadriplegia, and hemiplegia).

APPLICATION TO DOCUMENTATION
The skin incision was marked at the sagittal linear incision extending from the external occipital protuberance to approximately C2. The incision was infiltrated with 0.5% Marcaine with 1:200,000 epinephrine and opened with a scalpel. The midline fascia between the suboccipital muscles was used as a plane of dissection. The dorsal arch of Cl was exposed, and the muscle was dissected off the suboccipital bone bilaterally.

The term "suboccipital" assists in selecting the correct CPT® code for this craniectomy. Another location for a craniectomy could have been “subtemporal.”

Organs of Sense—Eye
Organs of sense are classified to the nervous system because they coalesce in nerve endings called sensory receptors.

The eye is a complex structure situated in the bony orbit or socket formed by seven bones: frontal, maxillary, sphenoid, lacrimal, malar bone, ethmoid, and palatine bones.

The eyeball has three layers: the retina (innermost), choroid (middle), and sclera (outermost). It is separated into an anterior segment filled with aqueous humor and a posterior segment filled with vitreous humor. The crystalline lens separates the two segments and refracts light as it enters the eye.

There are many adnexal or accessory structures to the eye, such as the eyelids, eyelashes, and the lacrimal system.

There are six ocular muscles that work in opposition to move the eye in multiple directions to facilitate a wide field of vision.

Nervous System

Source: William Crochot (File:Nervous system diagram.png) [CC BY-SA 4.0 (http://creativecommons.org/licenses/by-sa/4.0)], via Wikimedia Commons
Frequently Coded Conditions

The remainder of this chapter focuses on commonly coded diagnoses, many of which are frequently found in risk adjustment models. Coders must understand basic concepts and relationships among diseases, their progression, and related comorbidities. This knowledge will better equip the coders to understand clinical documentation and help coders to query treating providers. Always use the ICD-10-CM code book. The ICD-10-CM code book is the only diagnosis coding source for proper code selection.

Angina

Angina is often referred to as chest pain. This is not clinically accurate because angina pain is specifically a heart-related pain. Angina can be an ongoing, chronic condition that flares up occasionally; or it may be a sudden, unexpected symptom, which may be related to an impending heart attack (myocardial infarction). Coders must pay attention to how angina is described in the record.

There are code options for unspecified or NOS angina (I20.9) and unstable angina (I20.0). There is a category of combinations codes to report angina associated with a comorbidity of atherosclerotic heart disease (subcategory I25.1), a CABG (Coronary Artery Bypass Graft) or transplanted heart (subcategory I25.7), or post-infarction angina (I23.7).

Coders are instructed to report additional codes to identify related factors.

Use additional code to identify:

- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

For most risk adjustment models, there is a value differentiation between general or unspecified angina, versus unstable angina or angina complicated by additional comorbidities. Choosing the most specific and accurate diagnosis code is important for proper diagnosis coding and also guarantees an accurate risk adjustment factor will be assigned to the patient.

Unstable angina is often caused by, or complicated by, CAD. It can be associated with an increased risk of myocardial infarction, subsequent MI, or cardiac death, but it also is a descriptor of the symptoms that the patient has for their type of angina. Because it is considered an acute condition with life-threatening consequences, the American College of Cardiology and the American Heart Association guidelines recommend initial treatment of unstable angina in an Emergency Department (ER) (ACC, 2013, AHA, 2013). Some organizations have a rule that unless the patient is evaluated in the office prior to being sent to a hospital or ER for treatment, unstable angina should not be coded in an office setting.

The American Heart Association has a great description on the differences between stable angina and unstable angina (https://www.heart.org/en/health-topics/heart-attack/about-heart-attacks):

**STABLE ANGINA (Angina Pectoris)**

**Symptoms of Stable Angina** - The pain or discomfort:

- Occurs when the heart must work harder, usually during physical exertion
- Doesn’t come as a surprise, and episodes of pain tend to be alike
- Usually lasts a short time (5 minutes or less)
- Is relieved by rest or medicine
- May feel like gas or indigestion
- May feel like chest pain that spreads to the arms, back, or other areas

Patients who have a stable angina have symptoms of the above. In general, this type occurs with physical exertion, lasts for a short time, is relieved by rest and/or medicine, and does not present as a surprise to the patient as all episodes tend to be alike in presentation and the pain is always the same level.

**UNSTABLE ANGINA**

**Symptoms of Unstable Angina** - The pain or discomfort:

- Often occurs while you may be resting, sleeping, or with little physical exertion
- Comes as a surprise
- May last longer than stable angina
- Rest or medicine usually do not help relieve it
- May get worse over time
- Can lead to a heart attack

Patients who have unstable angina have symptoms of the above. In general, this type occurs when at rest or little exertion, lasts longer than stable angina, and can come as a surprise.

**Artificial Openings**

Artificial opening status should be coded when present because it affects patient care decisions and requires additional DME resources. Artificial openings may place the patient at risk for infection and may require continual monitoring for patency.
Chapter 9 Questions

1. A patient visits the provider to follow-up for her coronary atherosclerosis due to lipid rich plaque of the arterial bypass graft. What ICD-10-CM code(s) is/are reported?
   A. I25.709, I25.810
   B. I25.83, I25.709
   C. I25.83
   D. I25.810, I25.83

2. A patient presents with a long history of CKD. The patient states he has been extremely tired lately and very fatigued. The provider orders lab work. The patient returns and the provider documents anemia in chronic kidney disease and CKD 3. What ICD-10-CM code(s) is/are reported?
   A. Z87.448
   B. N18.30, D63.1
   C. N18.30, D63.1, Z87.448
   D. D63.1

3. The neurologist sees a patient in the hospital for CVA. The imaging shows occlusions of the basilar artery and the right carotid artery. The assessment is CVA of the basilar and carotid arteries. What ICD-10-CM code(s) is/are reported?
   A. I63.9
   B. I63.22, I63.231
   C. I63.9, I63.22, I63.231
   D. I66.8

4. A patient is seen for follow-up of DVT in the left saphenous vein. There is no medication list. What ICD-10-CM code is reported?
   A. I82.812
   B. I82.402
   C. I82.409
   D. I82.492

5. Patient presents for follow up of hypertension and heart disease. The patient was diagnosed after Lexiscan Myoview with left heart failure two years ago. The patient feels good with no chest pain of the last year and only one episode of dizziness. The cardiologist documents his assessment and plan below.

   “Hypertension - Continue current meds
   Left HEART FAILURE W LVEF 31-40%, would continue current medical therapy”

   What ICD-10-CM code(s) is/are reported?
   A. I10, I50.9
   B. I10, I50.1
   C. I11.0, I50.1
   D. I11.0
Compliance

1. **Answer**: d.

   **Rationale**: Review the CMS RADV checklist. The record should be legible with a signature or attestations from a valid provider type. A record may have multiple diagnoses in addition to the diagnosis targeted by the RADV audit. The record must be from a face-to-face visit.

2. **Answer**: a.

   **Rationale**: Risk adjustment has created the need to ensure providers document care of chronic conditions at least once per year. As a result, it is important for a documentation specialist to be able to identify chronic conditions and determine when a provider has documented treatment of any existing chronic conditions. To qualify for risk adjustment, chronic conditions must be documented in a way that is reasonable to determine that a physician is managing the patient and treating the chronic condition within the year.

   CMS considers the following conditions as chronic conditions:
   - Alcohol Abuse
   - Drug Abuse/Substance Abuse
   - Alzheimer’s Disease and Related Dementia
   - Heart Failure
   - Arthritis (Osteoarthritis and Rheumatoid)
   - Hepatitis (Chronic Viral B & C)
   - Asthma
   - HIV/AIDS
   - Atrial Fibrillation
   - Hyperlipidemia (High cholesterol)
   - Autism Spectrum Disorders
   - Hypertension (High blood pressure)
   - Cancer (Breast, Colorectal, Lung, and Prostate)
   - Ischemic Heart Disease
   - Chronic Kidney Disease
   - Osteoporosis
   - Chronic Obstructive Pulmonary Disease
   - Schizophrenia and Other Psychotic Disorders
   - Depression
   - Stroke
   - Diabetes

3. **Answer**: b.

   **Rationale**: In a CMS Risk Adjustment Data Validation (RADV), CMS identifies a random stratified sample of patients to audit. The sample is ⅓ of patients with a high-risk factor, ⅓ of patients with a medium risk factor, and ⅓ of patients with a low risk factor. Only Part C HCCs are audited in a RADV. The health plans must submit up to five best records from an acceptable treating provider, demonstrating those diagnoses as current in the year being audited that support the HCC values that were paid. Supplemental diagnoses (those that were not originally submitted via claims) may be approved if they are documented as current diagnoses in the record. The submission of all diagnoses (with HCCs) are cumulative; therefore, there may be a negative or positive financial outcome in such an audit. The purpose of the audit is to evaluate the appropriateness of risk scores of patients.

4. **Answer**: c.

   **Rationale**: In an HRADV, there is an Initial Validation Auditor (IVA) that reviews the sample to identify DOS that support HCCs (through diagnosis codes) for the chosen patients in the sample.
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