HCC Department Coding Newsletter

Arizona Priority Care™

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MONTHLY CODING SPOTLIGHT

CLINICAL DOCUMENTATION IMPROVEMENT

What are auditors looking for?

- Legibility
- Completeness
- Cloning/Copying
- Medical necessity
- Valid conditions billed
- Reported diagnoses must be documented
- Consistency throughout the record
- Valid provider signature and credential
- Incident to issues

Documentation Tips:

- Always have a status and plan
- Avoid using symbols
- Narrate diagnoses rather than relying on code selection
- Billed diagnosis code must match documentation
- Amendments should be in compliance with CMS guidelines
- Standard abbreviations only should be used
- Document and code to the highest level of specificity

Medical record criteria:

- Reason for the encounter, including relevant history, findings and test results
- At least two patient identifiers on each page of the record
- Record should substantiate service rendered and level of care
- Assessment and or impression for each diagnosis
- Document co-existing conditions that affect care and treatment
- CMS recommends the documentation show evaluation and monitoring or treatment of all conditions diagnosed
- EMR records must be password protected
- Scribes must also sign the note including their credential
- Progress notes should always have a chief complaint/reason for visit
- Avoid using "history of" for current or acute conditions requiring treatment
- Code all conditions that have resolved with a history diagnosis code

Remember, the medical record must be able to stand alone for the date of service audited.

AZPC Coding and Documentation materials are based on current guidelines and are to be used for reference only. Clinical and coding decisions are to be made based on the independent judgement of the treating physician or qualified health care practitioner and the best interests of the patient. ICD-10-CM, CPT and HCPCS are the authoritative references for purposes of assigning diagnoses and procedure codes to be reported. It is the responsibility of the physician and/or coding staff to determine and submit accurate codes, charges and modifiers for services rendered.

DOCUMENTATION SPECIFICS

NEOPLASMS

- Active cancer codes should only be reported when there is active/current treatment or patient "refusal' of treatment is documented
- Active treatment can include chemotherapy, antineoplastic drug therapy and hormone therapy
- Watchful waiting, active surveillance and expectant management are terms often used to allow time to pass before medical intervention or therapy treatment is used. These scenarios are considered 'active' cancer
- History diagnosis codes are used when the cancer has been eradicated and/or treatment completed . Routine follow up with an oncologist without active treatment should be documented and coded as a 'history of" condition

CIRCULATORY

- An acute CVA is a emergent situation that is rarely treated in the office setting, most cases are treated in the ER
- Follow up visits for a CVA should be coded as a history of diagnosis, although late effects can be coded as current
- PVD and PAD should not be documented as venous insufficiency
- ICD-10 presumes a causal relationship between hypertension with heart and kidney disease with combination codes

CHRONIC CONDITIONS

- All chronic conditions need to be documented annually
- Chronic conditions should be evaluated with a current status and plan
- HIV, lower extremity amputations, alcoholic dependency (in remission), major organ transplant and major depression (in remission) are all chronic conditions to consider each year
- Other easily identifiable conditions that can be overlooked are: artificial openings, purpura, respirator or dialysis dependency and morbid obesity

DIABETES MELLITUS

- DM can only be one type: Type I, Type II, or due to an underlying disease, it cannot be any combination of these
- There are combination codes for the more common manifestations and should be used instead of dual codes, some may require an additional code as in the case of the stage of CKD
- DM out of control and poorly controlled code to DM with hyperglycemia
- Avoid contradictory documentation of DM uncomplicated and then with a complication such as out of control

MENTAL DISORDERS

- Major depression is broken down into single or recurrent episodes, severity of mild, moderate or severe and in partial or full remission status. The provider must document these details. Required documentation specificity by the provider cannot be considered from the diagnosis code selected within the EMR
- Bipolar disorder can be reported similarly including psychotic features in the severe cases, but should NOT be coded with MDD
- Mental and behavioral disorders often times are found in patients with substance dependency and should be reported as well

CARDIOLOGY

- Heart failure and heart dysfunction should not be documented interchangeably as they code differently
- Specify the acuity of heart failure (acute, chronic, or acute on chronic)
- Identify the type of heart failure (systolic, diastolic, combined) and identify any underlying cause
- Causes of heart failure can include conduction disorders, dysrhythmias, hypertension, MI, and should be documented and coded in addition to heart failure

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