Coding Specificity and Documentation Integrity

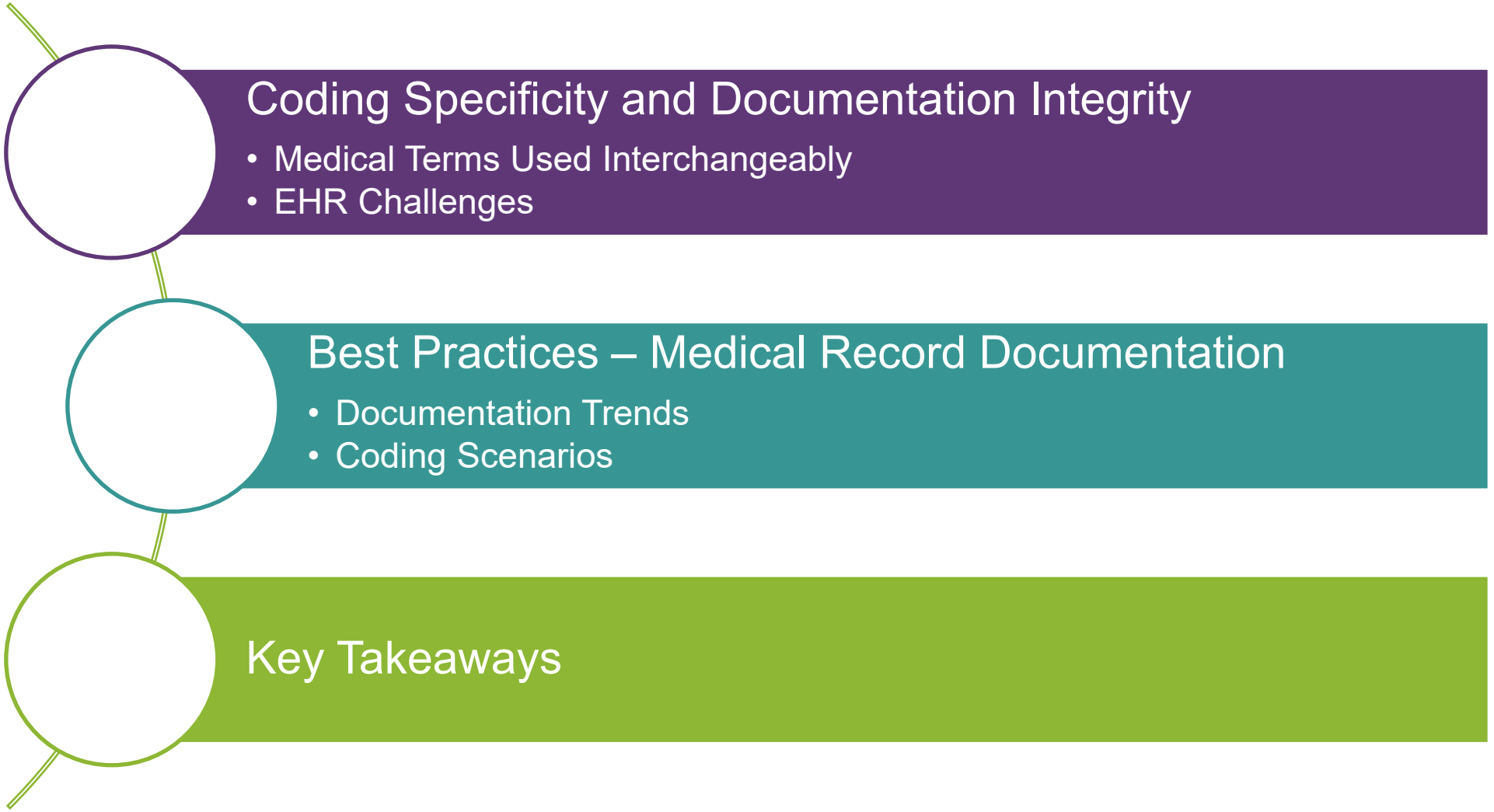
Introduction

Our members are our reason for being, our first priority is to provide our members with excellent care and service.

Our discussion today will focus on the importance of accurate medical record documentation, coding and why the process is ***critical*** to benefit the health of your patients - our members.

Best Practices - Coding Specificity

AGENDA



Best Practices - Coding Specificity

Common terms or phrases that are not interchangeable

- **Lesion ≠ Wound ≠ Ulcer**
    - The documented verbiage will direct a coder to a specific chapter and/or category in ICD-10
    - Condition may require a higher level of specificity when documenting
    - For example, for ulcers it is appropriate to document type, location, laterality and stage
- **Diastolic dysfunction ≠ Diastolic Heart Failure**
- **Weakness ≠ Hemiparesis (except when sequela of a CVA)**
- **Renal Insufficiency Syndrome ≠ Chronic Kidney Disease**
    - If CKD, identify Stage I-V or ESRD
- **Failure to thrive (common use) ≠ Malnutrition**
    - If Malnutrition: Type
    - If Protein-Calorie Malnutrition provide supportive evidence (labs, % weight loss, BMI <18.5)
- **Mass ≠ Neoplasm**

Best Practices – Documentation Integrity

- **Ensure that your EHR shows complete description of a condition**
- **Ensure that the description in your system matches description in the ICD-10 book**
- **Documentation must support code assignment**
- **Codes alone are not sufficient documentation, coders cannot report a code if the provider only documents a code on a progress note**

If the provider documents:	The coder can report:	Because:
E10.9	No codes	There is no documentation; only a code
E10.9 Diabetes	E11.9 Type 2 DM	Default for DM is type 2
E10.9 Type 1 DM	E10.9 Type 1 DM	There is enough information documented for more specific coding

Best Practices – Documentation Integrity

Most EHRs have features that can help providers cut down on the time a practitioner needs to document the medical record. These techniques can save time but can also pose a risk to the integrity of the document.

Copy/Paste - When using this function, provider must ensure that the information copied is updated and is accurate. Inappropriate use of this feature can lead to:

- ❑ Over-documentation – where irrelevant information is included in the medical record without additional support
- ❑ EHR cloning – inaccurate information may be placed in the patient's medical record; also makes it difficult to parse out new relevant patient information; **avoid conflicting documentation between different parts of the progress note**
- ❑ Can jeopardize patient safety by receiving inadequate medical care if medical decision making is based on inaccurate information.

Best Practices – Documentation Integrity

Templates – information that is auto-populated may not be relevant.

- ❑ Symbols on template might lead to confusion and/or ambiguous information
  - Seizure(s)/Epilepsy
  - RA/OA
- ❑ Template should be a reminder of questions to ask; should not have the answers already printed
  - Abnormal findings need to be addressed
- ❑ This feature could also lead to cloning wherein different dates of service look identical; there should be enough unique information for each DOS to show information has not been cloned

When using these features, be sure to review and update the information to reflect any changes in the patient's history or condition specific to that day's visit.

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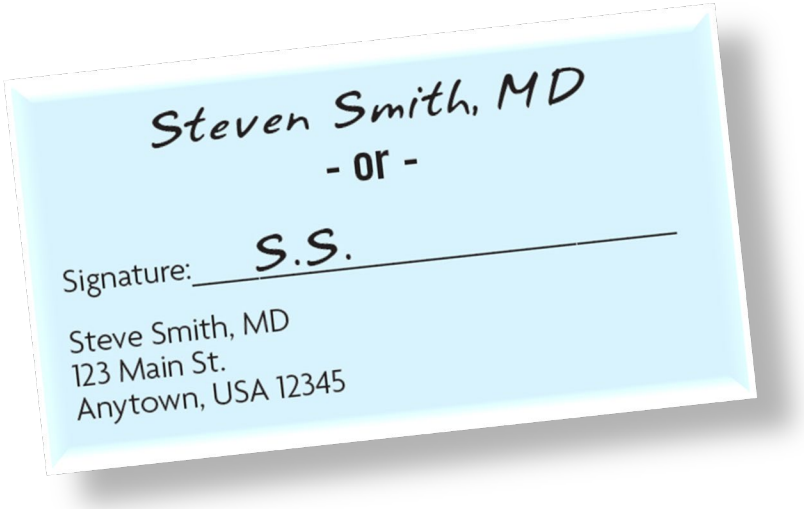
Best Practices
Medical Record Documentation

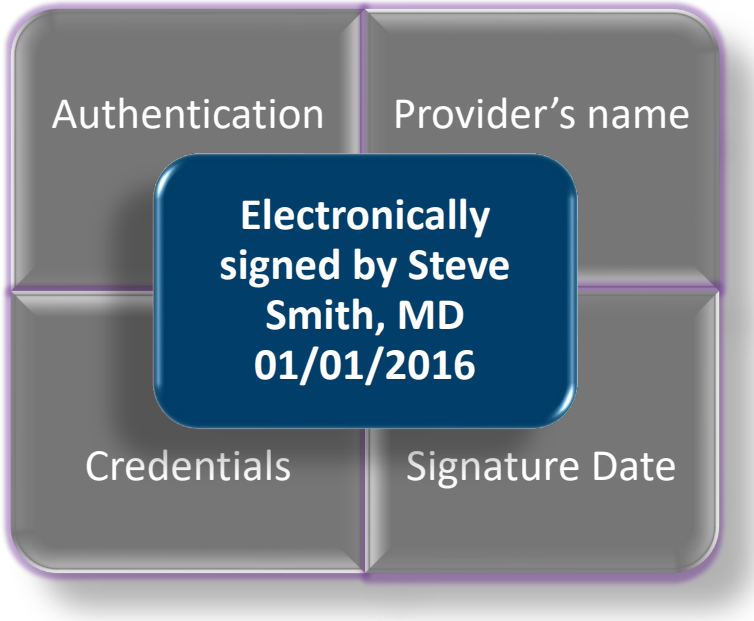
Best Practices – CMS Signature Requirements

Handwritten Signatures must include:



- ✓ Handwritten signature or initials if printed name and credentials are on progress note
- ✓ Legible handwritten signature with credentials
- ✓ If more than 2 names are listed on progress note, the provider signing the chart must circle his/her name
- ✓ CMS does not recognize Practice Name as rendering provider
- ✓ Dr. is a title, not a credential

Electronic Signatures must include:



- ✓ Signature name must reflect the provider of service
- ✓ The signature date should reflect the actual date of signature
- ✓ Record must be signed by the clinician that provided the service

Signature Issues

Missing Credentials

Electronically Signed By

Robert Smith on 5/15/2019

Unsigned

Visit Date: 05/29/2019 Reason For Visit: Hospital Follow up Status: Un Signed

Responsible Provider:

Michael Jackson, MD

Best Practices – Historical Conditions

"History of"

- In medical coding *"history of"* means the patient no longer has the condition
- Frequent documentation errors regarding use of "history of"
  - Coding a past condition as active
  - Coding history of when condition is still active
- Examples of conflicting documentation:

H/O CHF, meds Lasix	**vs.**	**Compensated CHF, stable on Lasix**
H/O COPD, meds Advair	**vs.**	**COPD controlled w/ Advair**
H/O of HIV	**vs.**	**HIV positive, asymptomatic**

Assessment of all ACTIVE conditions

- Each active diagnosis that is assessed must have a corresponding plan of care
- Use adjectives to describe the condition's status

Sample Language

Assessment	***Plan***
Diabetes, Stable	**Monitor A1C**
HTN, improving	**Continue meds**
CKD IV worsening	**Refer to Nephrologist**

Sample Progress Notes

Encounter - Office Visit Date of service: 01/15/18

Historical Diagnoses	ACUITY	START	STOP
(Z68.32) Body mass index (BMI) 32.0-32.9, adult			10/27/2017
(E11.29) Type 2 diabetes mellitus with other diabetic kidney complication		04/12/2016	10/13/2017
Encounter comment: due for a1c in dec by [redacted], MD on 10/04/16 A1c from 8 to 7.5 4/16 on acarbose and metformin by [redacted] MD on 04/12/16			
(I10) Essential (primary) hypertension	Chronic	09/25/2012	08/07/2016
Encounter comment: seems to tolerate lisinopril now by [redacted] MD on 07/18/16 increase to losartan 50 mg, lisinopril has been stopped due to cough by [redacted] MD on 02/28/14 no changes yet. by [redacted] MD on 09/03/13 good control by [redacted] MD on 03/27/13 better control now on lisinopril 20 mg by [redacted] MD on 11/06/12 re start lisinopril 20 mg daily by [redacted], MD on 10/04/12 hold lisinopril and observe by [redacted] MD on 09/25/12			
(F13.20) Sedative, hypnotic or anxiolytic dependence, uncomplicated	Chronic	04/12/2016	07/18/2016
Encounter comment: medication XAnax 0.5 mg # 30 per month needed, read below. by [redacted], MD on 04/12/16			
(E11.9) Type 2 diabetes mellitus without complications	Chronic	08/07/2012	04/12/2016
Encounter comment: very stable, continue same by luis bieler, MD on 03/27/14 A1C 6.3 stable on precose and metformin by [redacted], MD on 02/28/14 same no changes, excellent control on metformin and acarbose. by [redacted], MD on 09/03/13 continue metfomrin/ acarbose A1C is 6.4 by [redacted] MD on 03/27/13 on acarbose,metformin needs A1C by [redacted], MD on 02/12/13 continue acarbose. by [redacted] MD on 08/07/12			
Sedative, hypnotic or anxiolytic dependence	Chronic	04/12/2016	
Encounter comment: pt uses judiciously his xanax medication no more than once per day due to bouts of anxiety and panick attacks by [redacted] ([redacted] on 03/27/13			

Sample Progress Note

Encounter - Office Visit Date of service: 01/15/18

Subjective
dyspepsia, in his epigastrium he is taking some " laxative< , This has been going on for about 1 month. The discomfort tends to get better after he eats. It is very localized to the epigastrium only. Not accompanied with nausea or vomiting, he likes to eat spicy foods. He denies any shortness of breath or palpitations. He went to see the cardiologist and he is scheduled to have a stress test within the next few weeks. No medications were changed except that he was given something else for elevated blood pressure whose name he does not remember.

Assessment
Diagnoses attached to this encounter:
Old myocardial infarction [ICD-10: I25.2], [ICD-9: 412], [SNOMED: 1755008]
Percutaneous transluminal coronary angioplasty, postsurgical status [ICD-10: Z98.61], [ICD-9: V45.82],[SNOMED: 371822007] Comment: No longer on Plavix
Dyspepsia [ICD-10: R10.13], [ICD-9: 536.8], [SNOMED: 162031009] Comment: Treated empirically, avoid spicy food with decrease metformin to once a day. Empiric Zantac and Mylanta. They need referral if no improvement he needs referral to gastroenterology for colonoscopy
Anxiety disorder [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 197480006]

Sample Progress Note

Trends	Best Practices
Patient seen at beginning of the year; not all chronic/active conditions were assessed	Assess all active conditions/document in assessment w/plan and report via claim
Chronic conditions documented in Historical section (e.g. Diabetes, HTN, Sedative Dep.)	Chronic conditions should be brought down to assessment
Medications refilled at the time of encounter but condition was not found in assessment (Metformin, Albuterol)	Document condition under assessment and link medication refill to it
DM documented with and without complications	Always assess and document to the highest level of specificity

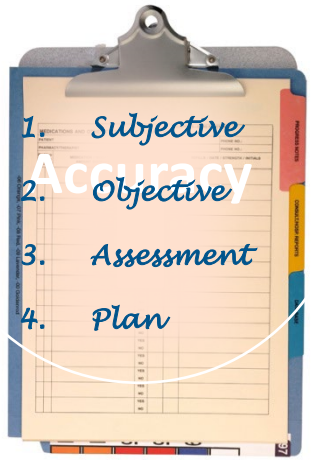
Best Practices – Documentation Strategies

Clear, Concise, Complete

Accuracy
- ✓ Documentation must support the diagnosis reported
- ✓ Watch for [illegible]licting data within no
- ✓ Documen[illegible]se/Effect relationsh

Specificity
- ✓ Document condition(s) assessed and what is being done[illegible]hat condition (R[illegible] referrals, monito[illegible]

Complete
- ✓ Incorporate/document relevant findings into progress note
- ✓ Rep[illegible]gnosis codes at [illegible]e per calendar [illegible]



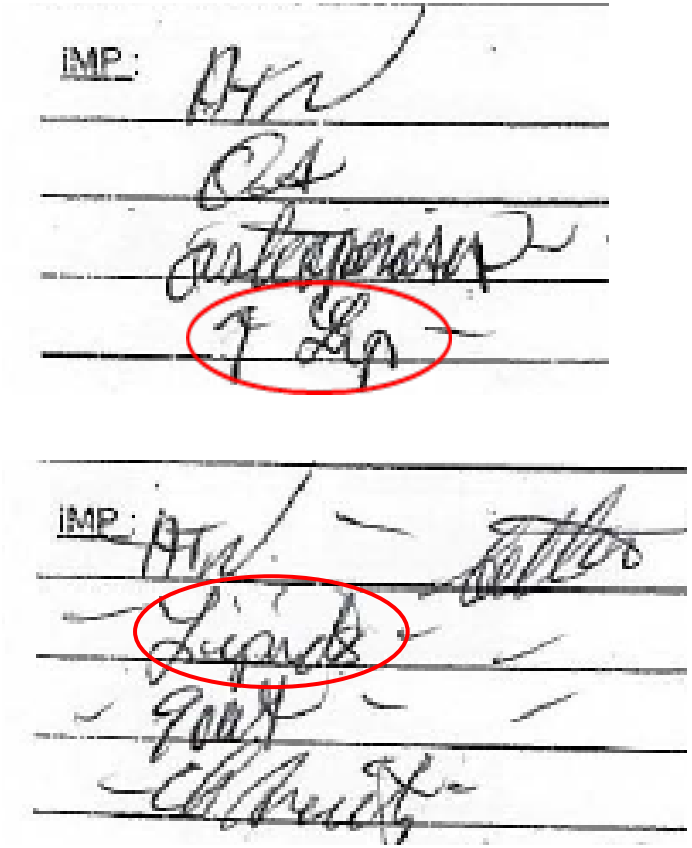
Consistency
- ✓ Chief complaint
- ✓ HPI, PMH, ROS, EXAM
- ✓ Comorbidities af[illegible] patient care
- ✓ Use standard abbreviations

CMS acceptable signature
- ✓ Handwritten
- ✓ Electronic
- ✓ CMS must be able to determine rendering provider

Documentation should paint a picture with words of the patient's condition and what occurred during each visit.

Documentation trends

Trend Identified



Best Practice

- Providers should avoid using symbols or arrows as these might not provide enough information to assign an ICD-10 code
- We encourage the use of standard abbreviations

Missing Plan of Care

Assessment / Plan:

Parkinson's disease

: CURRENT :

Hypertensive heart disease without heart failure

: STABLE :

Primary generalized (osteo)arthritis

: STABLE :

Hyperlipidemia, unspecified

Best Practices - Coding Specificity

Hepatitis*

- Type
  - -A, B, C or E
  - -Viral or Autoimmune
- Acute, Chronic, Unspecified

**New drugs appear to eradicate hepatitis C permanently; do not code as active if condition is cured. Cured means HEP C virus is not detected in the blood when measured 3 months after treatment is completed.*

Bronchitis

- Obstructive
  - Asthmatic
  - Mucopurulent
- -Acute
  - -Chronic
  - -Acute on chronic

Wounds/ Ulcer

- -Trauma
  - -Underlying Etiology
- -Location
  - -Stage
  - - Pressure or ischemic

HIV*

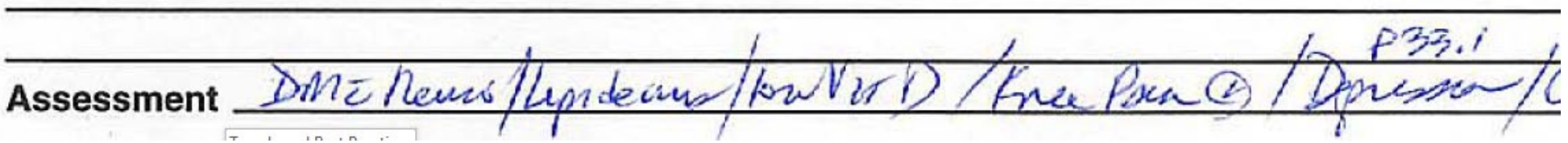
- -Asymptomatic
  - -Symptomatic
- -If symptomatic, identify all manifestations of HIV infection

***Z21**- Asymptomatic HIV – this code should be applied when the patient without any documentation of symptoms is listed as being "HIV positive", "known HIV, "HIV test positive", or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use **B20** in these cases.*

Diagnosis coding must mirror medical record. Detailed, specific documentation allows for accurate coding.

Documentation Trend

Trend Identified



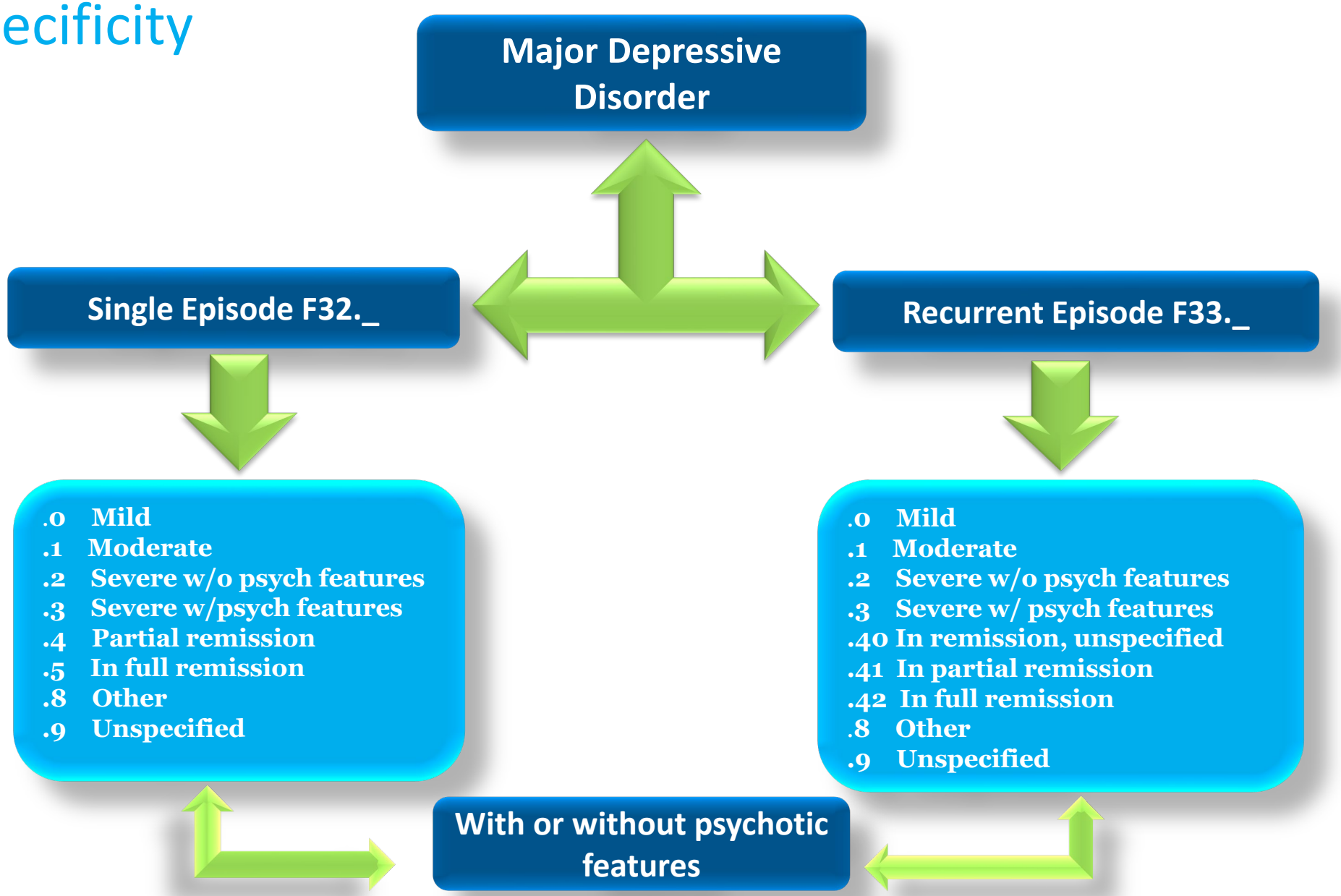
Major depressive disorder, single episode, unspecified – F32.9

Major depressive disorder, recurrent, moderate – F33.1

Best Practice

- ❑ Providers should include in the narrative description specific details for proper code assignment

MDD – Specificity



Diabetes Mellitus - ICD-10 Coding Alert

AHA Coding Clinic advises that, in accordance with ICD-10 Official Guidelines, the word "with" should be interpreted to mean *"associated with"* or *"due to"* when it appears in a code title, alphabetic index or instructional note in the tabular list. The classification *assumes a causal relationship* between the two conditions linked by these terms in the alphabetic index or tabular list – *Coding Clinic 1Q 2016 pages 11-12*

These conditions should be coded as related to diabetes, even in the absence of provider documentation explicitly linking them.

Diabetes, diabetic (mellitus) (sugar) E11.9
with
- amyotrophy E11.44
- arthropathy NEC E11.618
- autonomic (poly)neuropathy E11.43
- cataract E11.36
- Charcot joints E11.61Ø
- chronic kidney disease E11.22
- dermatitis E11.62Ø
- myasthenia E11.44

Coding Tip **-** A causal relationship between diabetes and above conditions is reported UNLESS:

- Documentation identifies another cause for the condition(s)
- Documentation clearly states the condition(s) are not caused by diabetes
- Documentation explicitly states underlying cause of condition(s) is unknown, under workup, etc.

Diabetes Mellitus - Coding Examples

ICD-10 Alphabetic Index	Documentation	Report as	
Condition linked to Diabetes in Alphabetic Index by "with" *Ex., CKD 3*	• Patient has DM, CKD and HTN • Causal relationship is not documented by provider	E11.22 – Type 2 DM with diabetic CKD I12.9 – Hypertensive CKD N18.3 – CKD Stage 3	*Causal relationship presumed as per Alphabetic Index*
Condition linked to Diabetes in Alphabetic Index by "with" *Ex., CKD 3*	• Patient has DM, CKD and polycystic kidney disease • Documentation indicates CKD is result of PKD	E11.9 – Type 2 DM Q61.3 – Polycystic kidney disease N18.3 – CKD Stage 3	*Another cause for condition documented*
Condition NOT linked to Diabetes in Alphabetic Index *Ex., Glaucoma*	• Patient has both DM and glaucoma • Causal relationship is not documented by provider	E11.9 – Type 2 DM H40.9 – Glaucoma	*Causal relationship neither presumed nor stated*
Condition NOT linked to Diabetes in Alphabetic Index *Ex., Glaucoma*	• Patient has both DM and glaucoma • Provider explicitly documents a causal relationship	E11.39 – Type 2 DM with other diabetic ophthalmic complication H40.9 - Glaucoma	*Causal relationship documented by provider*

Documentation Best Practices:

- Document underlying cause of conditions (when known) to allow for coding accuracy.
- ICD-10 presumes a causal relationship between DM and conditions indexed under "with" only when no other cause has been documented.

Diabetes Documentation Trends – E11.51

Subjective

Chief Complaint: Diabetes and Blood pressure follow up.

Assessment

Diagnosis

E118 Type 2 diabetes mellitus with unspecified complications, (Type: Chronic)

I739 Peripheral vascular disease, unspecified, (Type: Chronic)

Diabetes Coding Trends – “DM w/ other complications” E11.69

- For conditions not specifically linked by relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.
- Provider must specify “Other complication.”
- Use additional code to identify complication.

Assessment / Plan:

Type 2 diabetes mellitus with other specified complication

: STABLE : GlipiZIDE 10 mg tablet 1-1/2 tab(s) by mouth Daily

1 tab AM AC Breakfast, 1/2 tab PM

Diabetes Mellitus – Uncontrolled DM

"Uncontrolled" Diabetes Mellitus - ICD-9 vs ICD-10 Guidelines

ICD-9-CM Index to Diseases

Diabetes, diabetic (mellitus) 250.0 ☑

Note – Use the following fifth-digit subclassification with category 250:
0 type II or unspecified type, not stated as uncontrolled
Fifth digit 0 is for use for type II patients, even if the patient requires insulin
1 type I [juvenile type], not stated as uncontrolled
2 type II or unspecified type, uncontrolled
Fifth-digit 2 is for use for type II patients, even if the patient requires insulin
3 Type I [juvenile type], uncontrolled

ICD-10-CM Index to Diseases

Diabetes, diabetic (mellitus) (sugar) E11.9
with
hyperglycemia E11.65
hypoglycemia E11.649
uncontrolled
meaning
hyperglycemia – see Diabetes, by type, with, hyperglycemia
hypoglycemia – see Diabetes, by type, with, hypoglycemia

There is no code assignment for "uncontrolled" DM

Without further specification, correct code for "uncontrolled diabetes" is E11.9

Documentation Best Practices:

- Specify how patient's DM is out of control *(i.e., Does patient have DM w/ hyperglycemia, or DM with hypoglycemia?)*
- Incorporate lab, test findings into progress note, but remember that coders cannot interpret results.

Chronic Kidney Disease

Staging Chronic Kidney Disease			
Stage	**Severity**	**GFR**	**ICD-10 Codes**
Stage 1		≥ 90	N18.1
Stage 2	Mild	60 - 89	N18.2
Stage 3	Moderate	30 to 59	N18.3
Stage 4	Severe	15 - 29	N18.4
Stage 5 Stage 5, on dialysis ESRD		< 15	N18.5 N18.6 + Z99.2 N18.6 + Z99.2

Assign additional code for dialysis status

Documentation / Coding Tips

- **CKD s/p kidney transplant** - Patients who have undergone a kidney transplant may still have some form of CKD, as the transplant may not fully restore kidney function. Coders may assign a code for kidney transplant status in addition to the appropriate CKD code, based on the patient's post-transplant stage.
- **Diagnostic statement required** - Coders cannot report CKD or assign a CKD stage based on GFR levels; the provider's documentation of the condition (with stage) is required
- **Acute renal failure** - Report ***only*** if the patient is having an ***acute event during encounter***; do not continue to report once the acute condition has resolved
- **CKD requiring dialysis** - For patients undergoing dialysis, document dialysis status and any other pertinent information (dialysis schedule, presence of fistula, etc.)

CKD Documentation Trend – Stage not Documented

- HPI/CC present to discuss chronic conditions

Past Medical History

HLP
DMII with Retinopathy
HTN
Thrombocytopenia
Transaminemia
Hypothyroidism

Assessments

Hypertensive chronic kidney disease w stg 1-4/unsp CKD

: STABLE : Continue with current medication Losartan Potassium 100 mg tablet 1 tablet by mouth every day. DASH DIET. Avoid prolonged periods of dehydration. Will continue to monitor GFR.

Malignant Neoplasms

Neoplasm Coding Guidelines: Current Disease vs. Personal History

Current Disease:

An ICD-10 code for active cancer should be assigned for the primary malignancy **until treatment is completed**. This applies even when the primary malignancy has been excised and further treatment (e.g., chemotherapy, radiation therapy, or additional surgery) is directed to that site.

Personal History:

ICD-10 Guidelines

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal History of malignant neoplasm, should be used to indicate the former site of malignancy.

Extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.

Documentation Tip: Avoid use of the phrase "history of" when referring to active cancer as this means the condition no longer exists.

Documentation Trend – Unsupported Diagnosis

HPI/CC: 76 yrs male here today for one month follow and lab result.Had 1 episode of gross hematuria with pain self limited and without recurrency,had seen Dr.Rivera but was not satisfied and changed to another urologist Dr.Silva and is scheduled for abdominal CT.has Hx of Prostate cancer treated with external radiation

Past Medical History

Congenital Scoliosis R-Lung compressed,Prostate Cancer treated with radiation 2018

Assessment / Plan:

Malignant neoplasm of prostate

STABLE : Urology F/U

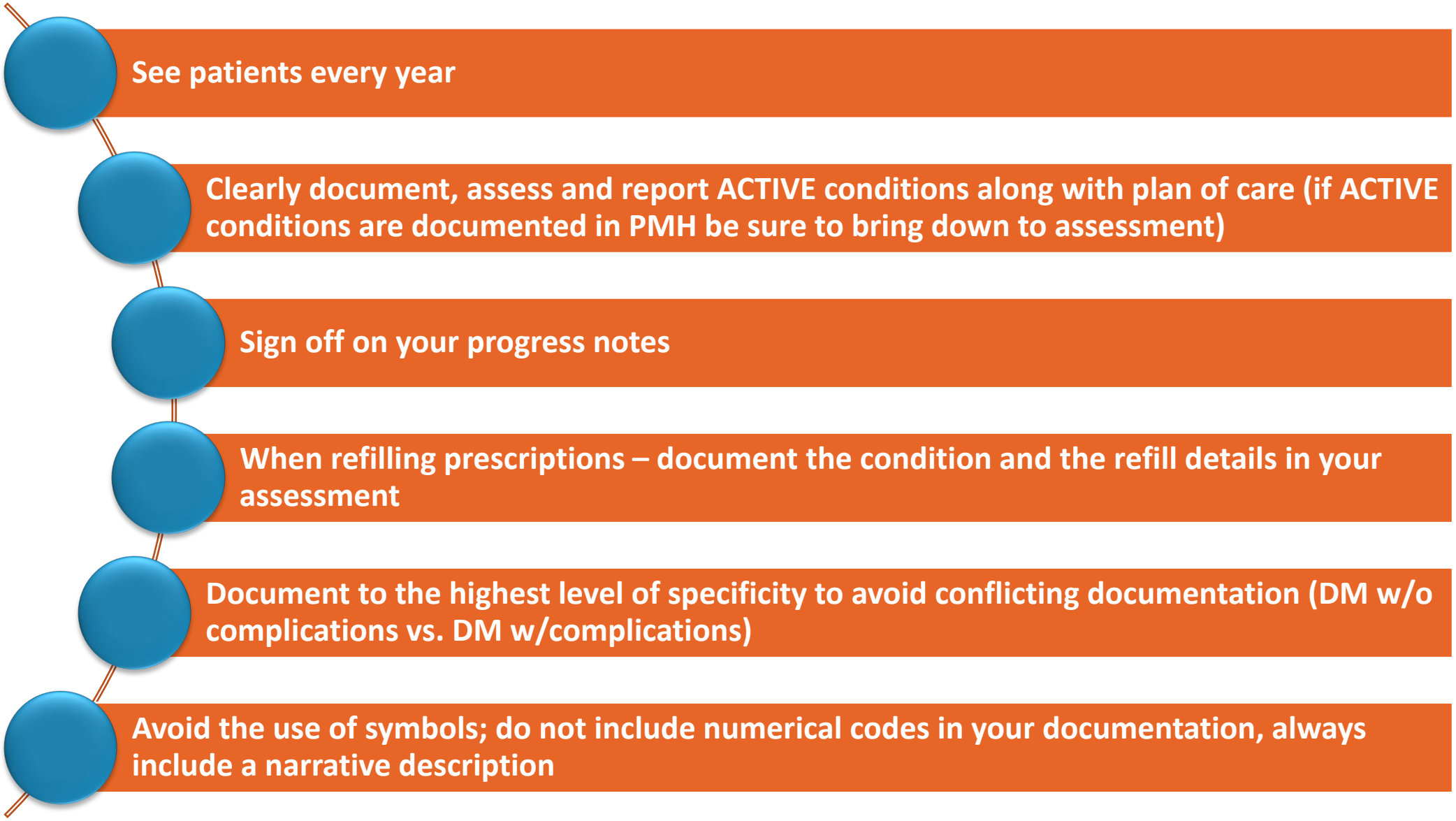
Malignant Neoplasms

Active Cancer / Personal History of Cancer / In Remission According to ICD-10

Active Cancer	In Remission	Personal History
Malignancy Present *Cancer is reported as active whenever it's present in the body* • Newly diagnosed • Patient Choice • Watchful Waiting • Unresponsive to treatment	Signs & symptoms of cancer are reduced, but patient considered to still have the disease. *Ex., Patient with AML was given 7-day course of induction chemotherapy to induce remission. Remission achieved, patient ready to begin consolidation therapy.* Diagnosis code: C92.0**1** **Fifth digit of "1" signifies in remission*	**NED + Treatment Complete** *Report a personal history of malignant neoplasm code when:* • Cancer has been previously excised or eradicated from its site, AND • There is no further treatment (i.e., *active treatment* of the malignancy) directed at the site, AND • There is no evidence of disease (NED) at the site
Active Treatment *Neoplasm previously excised, patient still undergoing:* • Chemotherapy • Radiation therapy • Targeted therapy • Hormonal therapy • Additional surgery	ICD-10-CM includes codes indicating remission status for: • Leukemia • Multiple myeloma • Malignant plasma cell neoplasm **No diagnosis code is provided in ICD-10 for lymphoma, in remission - select a dx code for active lymphoma*	ICD-10-CM provides separate codes for a past history of these conditions: • *Z85.6 – Personal history of leukemia* • *Z85.71 – Personal history of Hodgkin lymphoma* • *Z85.72 – Personal history of non-Hodgkin lymphoma* • *Z85.79 – Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues*

Documentation Tip: Personal history and the term "in remission" should not be used interchangeably.

Key Takeaways



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Additional Questions?
Contact us at raps@wellcare.com