CLINICAL DOCUMENTATION, CODING AND REPORTING

Through a variety of annual audits, the Centers for Medicare & Medicaid (CMS) validates that diagnoses submitted to health insurance plans match all clinical documentation. This is especially true for Medicaid and the Health Insurance Marketplace (HIM). For Medicaid, this involves the annual HEDIS* review. For HIM, this review is called Risk Adjustment Data Validation. In both audits, the diagnosis codes related to a claim are validated through medical records to confirm the patient's health status and/or completed services. Successful audits for health insurance plans ensure that plans pay claims accurately, manage costs and realize as much efficiency, as possible. So, if documentation matches the claim, the plan can avoid unnecessary payments back to CMS and other governing bodies.

TOP 10 SUGGESTIONS FOR CLEAR DETAILED DOCUMENTATION

Missing diagnoses and wrong diagnoses can and will affect each patient's medical record accuracy. Clear and detailed documentation can improve the accuracy of the coding. Here are the top 10 recommendations to help combat these discrepancies.

1 HISTORY VS. CHRONIC

Know when to document "history of" vs. "chronic."

- Past conditions that are not active and not being addressed should be documented as "history of." Use a follow-up code to explain a visit addressing a past condition, such as a yearly follow up for cancer in remission.
- If the long- standing condition continues to be monitored, evaluated, addressed or treated, document as a chronic condition.

2 EXCLUDES 1 RULE

Ensure the **EXCLUDES 1 RULE** does not apply to any of the documented diagnoses.

For example, J03- Acute Tonsillitis may not be coded with J02- Acute Sore Throat.

3 M.E.A.T.

Document how each chronic condition is being:

- Monitored
- Evaluated
- Addressed
- Treated

Condition must be treated on an ongoing basis to be reported.

4 ASSESSMENT & PLAN

And for all diagnoses…if you are documenting that the condition is currently being monitored, evaluated, addressed or treated, the diagnosis should be listed in the Assessment & Plan and coded as such.

5 ACTIVE STATUS CONDITIONS

Active status conditions should be reported at every encounter. Examples are missing limbs, colostomies and/or transplants.

6 CHRONIC VS. ACUTE

If a chronic diagnosis can be misconstrued as acute, be sure to document as chronic such as *chronic hepatitis.*

7 HIGHEST *(But Accurate)* SPECIFICITY

State conditions to the greatest specificity but only to the specificity that is supported in the documentation.

- Is it major depressive, disorder, single episode, severe without psychotic features? Or
- Actually, major depressive disorder, recurrent, mild?

The first is the highest specificity, but the second might be more accurate.

8 CONFLICTING DIAGNOSES

Is it Type 2 diabetes mellitus without complications, or

Is it Type 2 diabetes mellitus with diabetic polyneuropathy?

Document the appropriate diagnosis, consistently.

9 DIABETES

Speaking of diabetes…document any relationships that cause diabetes. Coders shouldn't assume. If the diabetes is caused by long-term steroid use, spell it out.

10 VALID RECORDS MUST HAVE:

- Electronic signature, or
- A legible written signature
- The Provider's credentials, and
- The date of the encounter and signature

Don't forget, missing or inaccurate diagnoses can impact claims, payments and audits. Clear and detailed records prevent these errors.

HEDIS – Health Effectiveness Data Information Set

If there is ever a question about how best to code a medical record for a Community Health Choice Member, please do not hesitate to contact us at RiskAdjustment@CommunityCares.com. We are also available for training coders, billers and providers.

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