

Coding and Compliance– Provider Education

In 2003 Medicare began funding Medicare Advantage health plans based on the level of illness of each enrolled member. The acuity of health plan membership is determined by the diagnosis codes that are documented in the clinical record and submitted to the plan on provider claims. The funding available to pay claims for IPA members is directly related to the premiums paid to the Medicare Advantage plans under this new Risk Adjusted model. Our goal in the CMO Coding Unit is to assist network providers in their efforts to appropriately document and code diagnostic services for the IPA membership.

WHAT IS A VALIDATION AUDIT? Medicare regularly audits your charts for proper documentation.

Important questions to ask yourself so that you are prepared:

- **Does your diagnosis have supporting documentation?** It is not enough to only state that your patient has hypercholesterol or hypertension. You must also document all medications, lab work and symptoms.
- **Have you provided sufficient and valid documentation for codes previously submitted?** The guidelines stress that you must provide specific documentation concerning each diagnostic code that you submit. It is not compliant to state under your assessment and plan that the patient is stable, see problem list, see above or no change.
- **Is your progress note compliant?** If there is no provider signature, provider credentials and/or date of service your progress note can not be used.
- **Are you submitting questionable diagnosis?** If you are seeing a patient in an outpatient setting you may not bill with a diagnosis described as “probable”, “questionable” or “rule out”. These descriptions are only valid for coding purposes in an inpatient record. Please do not bill with these diagnoses when they appear in your office chart.
- **When diagnostic reports confirm an initial diagnosis do you amend your charts?** When the report returns please amend your progress note stating the confirmed diagnosis along with the current date, your signature and credentials.
- **Are you properly documenting conditions?** Codes can only be captured through the physicians documentation. Please remember to state if a patient has history of, status of or is active for a condition.
- **Have you submitted a combination code without referencing both conditions?** If you submit code 574.00 –for Cholecystitis with Cholelithiasis and your assessment only states Cholecystitis then the auditor must code 575.10 - Cholecystitis unspecified.
- **Are you using approved abbreviations or symbols in your documentation?** If you use abbreviations or symbols that are not on an approved list the condition must be voided. Examples have been found in the charts stating that a patient has HTN ♥ Disease. This note only supports Unspecified HTN (401.9).
- **Have you submitted codes which are not supported by compliant linkage words?** If the patient has diabetes with renal manifestation (250.40) and CKD stage 4 (585.4), the physician must make this clear in their documentation by using the proper linkage words such as “diabetic nephropathy”. If the only wording used is DM and CKD then the only diagnosis that can be captured is Diabetes without mention of complications (250.00) and CKD unspecified (585.9).

Acute v. Chronic Hepatitis

If a patient has Chronic Hepatitis B or C it is imperative to document the word “chronic” in order to ensure proper coding. Simply documenting Hepatitis B or C does not give an auditor adequate information to presume that the condition is chronic verses acute. If the word “chronic” is not present, an auditor would code as unspecified or Acute Hepatitis B or C **which does not capture an HCC value.**

Documenting and Coding for Cancer

If a patient has had surgery and/or completed chemotherapy or radiation therapy, then a malignancy **CANNOT** be coded. You must use the personal history of the specified neoplasm code. Only when the patient remains on Tamoxifen or Lupron can you continue to code the malignancy.

Be Specific when Documenting Diabetes Mellitus

Physicians tend to document Type 2 Diabetes as “DM”, “NIDDM” or “DM controlled with meds”. This form of documentation does not “clearly” state which kind of Diabetes the patient has. Please be sure that you specify Type I or Type 2 and you make mention to whether the Diabetes Mellitus is controlled or not controlled.

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