Documenting & Coding
Risk-Adjusted Claims
Tips to Improve Claim Submission
The Importance of Correct Coding and Documentation

Correct and accurate documentation and coding is important for many reasons. When correct and accurate documentation is used, a patient’s history and physical condition is captured in his/her medical record. This information can be used to identify changes in health status and as criteria for disease management initiatives.
Documenting & Coding Risk-Adjusted Claims

Risk adjustment allows Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) to appropriately pay for the risk of the beneficiaries enrolled, instead of reimbursing an average amount regardless of the health status of members.

As part of this process, Medical Mutual relies on complete reporting of medical diagnoses in order to build an accurate health risk profile for each patient. Data is pulled from diagnosis codes reported on claims and medical record documentation from physician offices, hospital inpatient and outpatient settings. It is important to understand that complete and accurate coding benefits the patient, provider, and health plan in the following ways:

**Patients**
- Promotes collaborative support for optimal care of complex needs
- Early access to disease and medical management programs for optimal health and wellness

**Providers**
- Enhanced coordination of care by facilitating data exchange programs between Medical Mutual and the provider
- Reduced administrative burden by decreasing the requests for medical records for Healthcare Effectiveness Data and Information Set (HEDIS) and Risk Adjustment
- Improved overall patient health care evaluations process
- Helps to meet CMS provider obligations, which include the use of diagnosis coding standards in medical record documentation, reporting all conditions and diagnoses codes that exist on the date of an encounter

**Health Plan**
- Ensures that Medical Mutual is appropriately compensated for the risk of the members enrolled
- Identifies at-risk patients for enrollment into disease and medical management programs
We offer providers the following tips to help ensure accurate medical coding and billing compliance for risk-adjusted claims:

**Include all conditions related to health status**
- Always document and report comorbidities that affect the treatment of the primary diagnosis you are reporting.
- Frequently overlooked conditions/status factors when documenting include: transplant status, quadriplegia, dialysis status, current ostomies, amputations and HIV status.
- For cancer patients, document status of the patient, and include the treatment and care plan.
- Show causal relationships by using statements such as “due to,” “because of” or “related to.”
- Evaluate chronic conditions at least annually. Document the Monitoring, Evaluation, Assessment, and/or Treatment (M.E.A.T.) for each of the patient’s acute and chronic conditions.
- Ensure chronic conditions such as hepatitis or renal insufficiency are documented as chronic.
- Include a mandatory manifestation code or a causal relationship for diabetic conditions when applicable.
- Do not document “history of” for diseases the patient currently has. Use terms such as “controlled,” “asymptomatic” or “managed” to describe an existing condition (e.g., chronic heart failure controlled on a beta blocker).

**Be as specific as possible.**
- Diagnosis codes justify the services and procedures billed. The more precise the documented diagnosis is, the more likely the services and procedures will be supported.
- CMS does not recognize probable, suspected, rule out, working or questionable diagnosis codes in patients’ outpatient medical records.
- Code the signs and symptoms the patient is presenting with if there is not an established definitive diagnosis.

**Double-Check Quick Tips**
- Use only standard abbreviations.
- Include a legible signature with credentials.
- Authenticate the Electronic Health Record (i.e., make sure it is electronically signed).
Top Coding Errors

Coding errors can result in reduced or delayed reimbursement and contribute to an incomplete record of your patient’s health. The top coding errors and correction tips include:

1 **Incorrectly using historical conditions.**
   
   Avoid using the phrase “history of” to describe current or chronic conditions that are still present, active or ongoing. A medical condition described as “history of” means the condition was in the past and no longer exists. If it is not clear that the condition still exists, coders should not code such conditions as current.

   **Example**
   The final assessment includes “cerebrovascular accident (CVA).” A diagnosis code may be erroneously assigned for this condition as if it is current (163.50), when in reality the patient experienced a CVA two years ago and has no residual deficits (Z86.73).

   **Correct Action**
   In this scenario, the condition should have been documented as “history of cerebrovascular accident two years ago with no residual deficits.”

   **Example**
   A patient with a history of prostate cancer that has been eradicated in the past presents to the office for a six-month follow-up visit for evaluation, examination and lab test (prostate specific antigen, or PSA) to monitor for reoccurrence. The assessment section states “prostate cancer,” which classifies to code C61 (the code for current prostate cancer). This is an error in documentation that results in an error in ICD-10-CM coding.

   **Correct Action**
   The correct way to document this condition is: “history of prostate cancer—PSA shows no evidence of cancer reoccurrence. Continue to monitor PSA every six months to check for recurrence.” History of prostate cancer classifies to code Z85.46 (personal history of malignant neoplasm of prostate).
Failing to code to the highest level of specificity.
Medical coders must carefully review the entire medical record with attention to the details of a specific diagnosis description. The coder must look for documentation of one or more of the following:

- The specific site or location on the body or within a body part.
- The specific type or stage of the condition.
- The condition being linked to another condition in a causal relationship. It is incorrect to code two conditions as linked in a cause-and-effect relationship when the medical record documentation does not link them. The medical coder is not allowed to make assumptions and must code the conditions exactly as they are documented within the medical record. (An exception to this rule is if the word “with” in the ICD-10 Code book Alphabetical Index is sequenced immediately following the main term, a causal relationship is assumed unless the provider specifically documents otherwise.) It is also incorrect to code two conditions separately when the medical record documentation links them in a causal relationship.

Example
The medical record documents a diagnosis of “diabetes mellitus type II, controlled with peripheral neuropathy.”

Correct Coding

Applying a clinical interpretation to medical record documentation.
Coders should avoid reading into or clinically interpreting medical information. A diagnosis that is not documented by the treating healthcare provider should not be assigned.

Example
The final impression in a medical record is chronic kidney disease (with no stage specified). The medical coder notes that the record documents a glomerular filtration rate (GFR) of 45. Since the coder knows a GFR within the 30 to 59 range equates to stage 3, code N18.3 (chronic kidney disease stage 3) is assigned. This is not correct, as there is no documentation of stage 3 in the record.

Correct Action
It is the healthcare provider’s responsibility to document the stage of chronic kidney disease. When no stage is documented, code N18.9 (chronic kidney disease, unspecified) must be assigned.
4 Coding uncertain diagnoses as confirmed (in the outpatient setting).
The ICD-10-CM Official Guidelines for Coding and Reporting (Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services, H. Uncertain Diagnosis) advises as follows:

“Do not code diagnoses documented as ‘probable,’ ‘suspected,’ ‘questionable,’ ‘rule out,’ ‘working diagnosis’ or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty such as symptoms, signs, abnormal test results or any other reason for the visit.”

Example
The lack of specificity in coding in the final assessment documents “breast cancer,” so the coder assigns C50.919 (malignant neoplasm of breast (female), unspecified site). However, upon closer review, the medical history documents a biopsy one week ago of a lump found in the upper, inner quadrant of the right breast, which was positive for adenocarcinoma.

Correct Coding
The most accurate ICD-10-CM code for this documentation is C50.211 (malignant neoplasm of upper-inner quadrant of female breast).

5 Misinterpreting abbreviations and acronyms.
As a best practice, healthcare providers should limit or avoid the use of abbreviations or acronyms. Some standard abbreviations and acronyms have multiple meanings. The meaning of the abbreviation or acronym can often be determined based on context, but this is not always true. Thus, coding errors can occur.

Example
The following are abbreviations and acronyms for common diagnoses with multiple meanings: MI, RA and MDD.

Correct Coding
Best practice documentation includes the initial notation of an abbreviation or acronym spelled out in full with the acronym in parentheses. Subsequent mention of the condition can be made using the acronym. The diagnosis should again be spelled out in full in the final impression or plan. For instance:

- MI can mean myocardial infarction, mitral insufficiency or mitral incompetence.
- RA can mean rheumatoid arthritis or refractory anemia.
- MDD can mean major depressive disorder or manic depressive disorder.
Failing to code historical and status conditions.
The ICD-10-CM Official Guidelines for Coding and Reporting reads, “Personal and family history codes are acceptable on any medical record, regardless of the reason for the visit. A personal history of an illness, even when no longer present, or a family history of a condition, both represent important information that can influence patient care, treatment or management.”

Other relevant excerpts from the ICD-10-CM Official Guidelines for Coding and Reporting include:

- Personal history codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment but has the potential for recurrence. Therefore, he or she may require continued monitoring.
- Personal history codes may be used in conjunction with follow-up codes to explain the need for a test or procedure.
- Family history codes are used when a patient has a family member with a particular disease that causes the patient to be at higher risk of also contracting the disease.
- Family history codes may be used in conjunction with screening codes to explain the need for a test or procedure.
- Status codes indicate a patient is a carrier of a disease, has the sequel (residual of a past disease or condition) or has another factor influencing his or her health status.

Example
A patient has prosthetic or mechanical devices resulting from past treatment. A status code is informative because the status may affect the course of treatment and its outcome. A status code is distinct from a history code, which indicates the patient no longer has the condition. Status codes should not be used with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code.

Example
Code Z94.1 (heart transplant status) should not be used with code T86.20 (complications of transplanted heart). The status code does not provide additional information. The complication code indicates the patient is a heart transplant patient.
Tools and Resources

For more information about documentation and coding for risk-adjusted claims, visit:

**American Academy of Professional Coders (AAPC)**
AAPC.com

**American Health Information Management Association (AHIMA)**
BoK.AHIMA.org

**Centers for Medicare & Medicaid Services (CMS)**
CMS.gov

**Medical Mutual’s Provider portal**
Provider.MedMutual.com