HCC Tips for Coders

Note: CMS regulations require that services be medically necessary, have documentation that support the claims, and be ordered by a physician. According to the National Committee for Quality Assurance (NCQA) it is an essential component of quality patient care to have consistent, current, and complete documentation in the patient's medical record. Compliance and accurate reimbursement depend on the correct application of codes, which is based on physician documentation. Patient care, documentation, coding, and compliance go hand-in-hand. It is not possible to assign the most specific and most appropriate diagnosis code without complete, detailed documentation regarding the patient's disease or injury.

Medical Record: "The medical record serves a number of purposes. Foremost, it must chronicle the histories, diagnoses, and treatments of the patient to ensure the safety and efficacy of care, and to improve the patient's health. The record must reflect the decision making, consents, and professionalism that will protect the physician from medicolegal claims. The record must also be complete so that another physician could, if necessary, assume care of the patient based on the content of the medical chart." *(Risk Adjustment Documentation and Coding, by the AMA; Chpt 3 Clinical Documentation and Coding for RA page 61)*

Difference between Traditional coding and RA coding: Traditional coding focus is on the Chief complaint (CC) and capturing the reason for the visit and the treatment of the CC. "RA coding, however, puts equal emphasis on the CC and chronic conditions of a patient, because the chronic conditions affect the patient's overall health status, resource requirements, and decision making regarding the CC." ." *(Risk Adjustment Documentation and Coding, by the AMA; Chpt 3 Clinical Documentation and Coding for RA page 61)*

Note to Coder and Providers: " Coders should check the coding performed by physicians and correct it as necessary. Codes are not documentation, so coders do not need to be concerned they are altering documentation when they disregard a code selected by a physician. Correct coding and billing are joint efforts between physicians and coders, wherein the physicians' primary focus is on the patient and the documentation that follows from an encounter, while the coder's focus is on the abstraction after the encounter. " . *(Risk Adjustment Documentation and Coding, by the AMA; Chpt 3 Clinical Documentation and Coding for RA page 85)*

Documentation Tips:

1. Per ICD.10.CM Guidelines Section IV(C) , " [f]or accurate reporting ICD.10.CM diagnosis codes, the documentation should describe the patient's conditions, using terminology that includes specific diagnosis, as well as symptoms, problems, or reasons for the encounter. There are ICD.10.CM codes to describe nearly all of these.
2. Evaluate conditions listed in a problem list for chronicity and be sure there is complete documentation to support that diagnosis in the medical record such as history, medications, and final assessment. If the condition no longer exist or is not being receiving any treatment remove from the problem list or change to a "history of" code.
3. Identify causal relationships or manifestations, as appropriate, with the documented diagnosis using the phrases "due to", "caused by" so the coder can link conditions for more accurate risk coding.
4. Identify the documented condition as acute or chronic
5. Identify the anatomic location of the documented condition with as much specificity as possible.
6. Document the clinical findings/indicators that support the diagnosis documented.
7. Document all conditions that coexist at the time of the visit or affect patient care treatment or management.
8. Be sure to include all information pertinent to the encounter in the note to reduce the need for coders having to query. **(IF YOU THINK IT……INK IT)**

9. Coders cannot code a diagnosis documented as “probable”,” suspected”, “questionable”, “rule out”, compatible with”, “consistent with” or “working diagnosis” or other similar terms indicating uncertainty. Rather, document the conditions to the highest degree of certainty for the encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit so coders can accurately code this visit.
10. Do not document with acronyms or abbreviations. There is often more than one meaning leading to possible errors in coding.
11. Do not forget the Status Condition codes. . A Status condition is defined as the element within a patient’s medical profile that is significant for current or future medical risk. A significant number of medical-Status codes risk adjust, and these Z codes are among the most often overlooked or missed in RA coding. Document them in the visit note so a coder and capture that code.
12. Have a compliant and appropriate query process in place to allow coders to query providers to clarify documentation timely. One of the most important relationships is between the coder and the provider to correctly capture the entire patient medical story.
13. Do not code using “history of” unless the patient’s past medical condition no longer exists and in not receiving any treatment.