

Important Physician and Provider Accurate Coding Responsibilities

Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Reviews

In this Medical Office Notes, Passport Advantage (PAD) explains physician and provider responsibilities for accurate diagnosis coding, as required by the Centers for Medicare & Medicaid Services (CMS).

What are your responsibilities?

Physicians must accurately report the ICD-9-CM diagnosis codes to the highest level of specificity. This requires accurate and complete medical record documentation. Accurate coding begins with complete documentation.

Documentation Considerations

Please ensure you and your staff are familiar with the following guidelines and tips for accurate coding:

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Medical records and codes are subject to CMS validation.
- Acceptable documentation is clear; concise, consistent, complete, and legible.

Physician Documentation and Communication Tips

- Document and report co-existing diagnoses.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- **Ensure physician signature and credentials are on each date of service documented.**

SOAP Notes

The SOAP note format assists both the physician and record reviewer/coder in identifying key documentation elements. SOAP stands for:

- **Subjective:** How the patients describe their problems or illnesses.
- **Objective:** Data obtained from examinations, lab results, vital signs, etc.
- **Assessment:** Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.
- **Plan:** Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

Per the ICD-9-CM Official Guidelines for Coding and Reporting (October, 1, 2003), providers must code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

What is the Risk Score Adjustment Model?

This method of data collection and analysis:

- Relies on the ICD-9 diagnosis code to reflect the actual health status of all Plan beneficiaries; and
- Allows CMS to adjust PAD reimbursement according to expected costs.

To accomplish accurate representation, PAD must obtain health status documentation from the diagnoses contained in claims data, and/or the information contained in a member's medical record.

What is the significance of the ICD-9-CM Diagnosis code?

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are identified as:

- 3 to 5 digit codes used to describe the clinical reason for a patient's treatment; and
- a description of the patient's medical condition or diagnosis (rather than the service performed).

Diagnosis codes are used by CMS to ensure plans with a less healthy membership – and thus higher costs – are reimbursed at the appropriate level.

Accurate payments to PAD help ensure that providers are reimbursed appropriately for services provided to PAD members.

Why are retrospective chart reviews necessary?

Although PAD captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

Have you coded for all chronic conditions for the member?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

- Amputation status;
- Bipolar disorder;
- Cerebral Vascular Disease;
- Chronic Obstructive Pulmonary Disease;
- Chronic Renal Failure;
- Congestive Heart Failure;
- Coronary Artery Disease;
- Depression;
- Diabetes mellitus;
- Dialysis status;
- Drug/alcohol psychosis;
- Drug/alcohol dependence;
- HIV/AIDS;
- Hypertension;
- Lung, Upper Digestive Tract, and other severe cancers;
- Metastatic Cancer and Acute Leukemia
- Multiple sclerosis;
- Paraplegia;
- Quadriplegia;
- Renal failure;
- Schizophrenia;
- Simple Chronic Bronchitis; and
- Breast, Prostate, Colorectal and other cancers and tumors.

Questions?

Contact your Provider Relations representative, or the Provider Relations department at (502) 585-7943 for more information.