Industry Collaboration Effort
Health Plans • Providers • Associations
Communication for Collaboration

Documentation Hints

Medicare's guidelines state," Code all documented conditions which co-exist at the time of the visit that require or affect patient care or treatment".

The goal of complete and accurate documentation in progress notes is to help CMS evaluate the costs of taking care of the patient and pay Medicare Advantage plans accordingly. The goal is not to justify the CPT codes or E/M office visits that the physician bills.

The BASICS

Document at least once a year

- Chronic conditions (CHF, COPD, DM)
- Active status conditions (amputations, colostomy)
- Pertinent past conditions (Old MI)
- All conditions that require medication
- Conditions that affect the patient's day to day life

Be specific (when applicable)

- Major depression, not depression
- Chronic bronchitis, not bronchitis
- Atrial Fibrillation, not cardiac dysrhythmia
- Malnutrition, not loss of weight
- History of MI, not CAD

Words to use

- Diabetic neuropathy or neuropathy due to diabetes or neuropathy caused by diabetes
- Hypertensive heart disease
- Compensated CHF
- Describing words---Acute, chronic, in remission, exacerbation, stable, compensated

Some conditions require 2 codes and both codes must be documented

- Diabetic manifestations (diabetes and the manifestation)
- Pressure ulcers (site and stage)
- Hypertensive renal disease (hypertension code-403.x and renal code)
- Cirrhosis due to alcohol (cirrhosis and ETOH dependence active or in remission)
- Pneumonia (pneumonia and organism)
- Infection (infection by site and organism)

Be careful about tense

- History of MI, not MI (after 8 weeks post)
- History of thyroid cancer, not thyroid cancer (after all treatment is done)
- History of stroke V12.54 or sequelae 438.x , not CVA (once the patient leaves the hospital)

Status code – A current condition that may affect the course of treatment or its outcome (amputation status, artificial opening status, old MI)

History code – The patient no longer has the condition but has periodic testing to make sure the condition does not reoccur

Late effects code – residual effect after the acute event has happened. There is no time limit on using the late effects code. (hemiplegia from stroke)

Rule out / possible codes– **Do not code** it until you are sure the patient has the condition. Possible, probable or questionable cannot be coded. Use signs and symptoms until a definitive diagnosis is found.

Do you mean?

If you document	Do you really mean
open wound	skin ulcer
bronchitis	chronic bronchitis
asthma	chronic obstructive asthma
cardiac dysrhythmia	atrial fibrillation
cardiac dysrhythmia	paroxysmal tachycardia
anemia of chronic disease	protein calorie malnutrition
anemia of chronic disease	cachexia
loss of weight	protein calorie malnutrition
cancer	history of cancer
chest pain	angina
essential tremor	Parkinson's
CAD	angina
CAD	old MI
CVA / stroke	history of CVA

Things you need to know

Each medical record must contain

- Date of service
- Patient name
- Provider signature and credentials
- Handwriting that is legible (to someone else)
- Only industry standard abbreviations
- Each medical condition needs to have an evaluation statement

Medications may indicate a condition, but cannot be coded unless you write the words. Make sure for every medication you are refilling you are listing and addressing the diagnosis on a progress note at least once a year.

Direct your office staff to:

- Try to schedule all patients at least once a year for a visit
- Update the super bill each year -- ICD-9 codes change Oct 1st and CPT change Jan 1st
- Submit all diagnosis codes on the bill. If your billing system won't allow it look into ways to solve this. Get your IPA involved.
- Create superbills that are user-friendly to both providers and staff

Progress Note Example:

Patient Name: Jana Patient
DOB: 1/1/1945

Date: July 20, 2009

Subjective: Patient is a very pleasant 64-year-old female who is here to follow up on recent mammogram and her other conditions.

Objective:

Physical Exam:

Vitals: Temperature 99.3 Respirations 20 Pulse 97 Blood Pressure 149/85

GENERAL: Pleasant, well nourished, well-developed in no acute distress
SKIN: Warm, dry, with good capillary refill, no rashes or jaundice
HEENT: Head: NC/AT, Eyes: Conjunctiva are clear, Ears: TMs clear b/l, Pharynx: Clear without exudates
NECK: Supple, no LAN, no thyroid masses
BREASTS: Deferred
HEART: Regular rate and rhythm
LUNGS: CTA b/l
ABDOMEN: Soft, non-tender, non-distended, with no palpable masses
NEURO: Cranial nerves II through XII are grossly intact with no motor or sensory deficits
EXTREMITIES: No clubbing, cyanosis or edema.
BACK: No CVAT, no lumbar spinal tenderness
MUSCOSKELETAL: Rt shoulder with some discomfort at the limits of abduction and external rotation

Mammogram screening from 7/9/09 showed a negative mammogram with recommendation for yearly screening.

Recent kidney testing from 3/3/09 showed a creatinine of 1.10, with an estimated GFR 54, and a BUN of 16.

Assessment:

1. Hypertension 401.9
2. Type 2 diabetes mellitus with renal manifestations, currently controlled 250.40
3. Right shoulder osteoarthritis 715.11
4. Congestive heart failure, controlled 428.0
5. Chronic kidney disease stage 3 585.3

Plan: Continue on current blood pressure medications and recheck in 4 weeks at the office. Tramadol 50mg 1 to 2 tablets every 6 hours was refilled for arthritic shoulder pain. Blood sugar in the office was 117. Patient will continue with present treatment with metformin. Congestive heart failure is being monitored by her cardiologist, Dr Heart, and is presently controlled. Recent kidney testing from 3/3/09 showed a creatinine of 1.10, with an estimated GFR 54, and a BUN of 16. Will recheck next month.

Joe Doctor, MD
Joe Doctor, MD

Risk Adjustment and *New* Tools to Ensure Accurate Documentation

December 2009

Is your documentation sufficient to fund the care for your sicker members?

Diabetes Mellitus and Chronic Kidney Disease

The Centers for Medicare and Medicaid Services (CMS) have implemented a new risk adjustment payment system, called the Hierarchical Condition Category (HCC) payment model. A method used to adjust payment based on health status and demographic characteristics of an enrollee.

Case Scenario 1: Mrs. Smith, an 85 year old white female who lives at home alone. Patient presents to your clinic with symptoms consistent with UTI. Patient feels more tired and have less energy, poor appetite. She had a heart attack (MI) a year ago. Patient has mild degree of malnutrition, frail and had lost 30 lbs within 6 months. Dr. Lee perform a urinalysis which shows white cells and leukocyte esterase and microalbuminuria. Serum creatinine- 1.4. Patient has been complaining of urinary discomfort, weakness, have dry and itchy skin for the past 6 months. Patient's past medical history: Diabetic Nephropathy, R BKA status-stable, MI-stable and UTI. Her serum creatinine 6 months before that was 1.3. Labs findings revealed Chronic Kidney Disease stage 3.

Plan: DM-Glucophage 500 mg BID, UTI-Cipro, Mild degree malnutrition- Ensure supplements. Return to clinic in 3 months. Referral to Nephrologist- Dx: CKD 3.

What Many Providers Do:

Assessment: DM and UTI

Coding Assignment:		**ICD-9**	**CMS Risk Score**
	DM	250.00	.162
	UTI	599.0	0
Demographic Score			**.44**
Total RAF Score			**.602**

What does the documentation say and how to appropriately document these diagnoses in the progress notes?

Assessment: Diabetic Nephropathy, Old MI, CKD Stage 3, Mild Degree Protein Calorie Malnutrition, R BKA status.

Correct coding assignment:			
	DM Renal Manifestation	250.40	.508
	Nephropathy	583.81	
	Mild Degree Malnutrition	263.1	.856
	OLD MI	412	.244
	BKA Status	V49.75	.678
	Chronic Kidney Dse. Stage 3	585.3	.368
Demographic Score			**.44**
Total RAF Score			**3.094**

Case Scenario 2: Smoker's cough, Hypoxemia and CHF

Definition: Hypoxemia is deficient oxygenation of the blood. Low oxygen levels can be present w/o asphyxiation. Excludes: Asphyxia and hypoxemia if(due to hypercapnia).

Mrs. Taylor is a 75 year old female who presents to your office to see Dr. Tan. Pt was discharged from hospital 3 days ago. Chief complaints: coughing for several weeks, shortness of breath, feels tired easily. Social history: Lives at home with husband, smokes 2 packs a day for 40 years. PMH: Pt was diagnosed with CHF with Dr. Sims-Cardiologist. EF -45%. Oximeter O2 Sats on RA is 78%. VS: 135/85, R-26, P- 90. Pt has O2 at home 3-4 liters per minute continuous. ROS: Respiratory: smokers cough, hypoxic. Tachypnea. Reviewed labs from DC summary: ABG O2 sats—82% PAO2-55 mmHg.

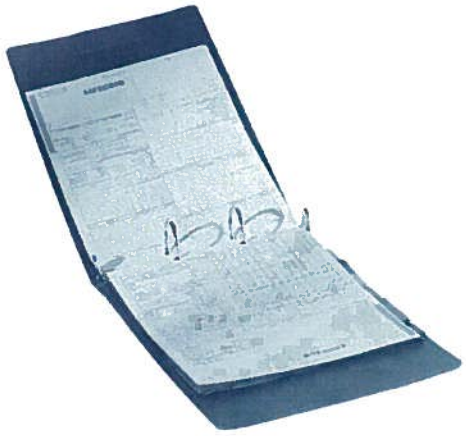
Plan: Meds refill: Coreg, Lasix and Vasotec. Home O2 at home. Referral to Pulmonologist and Cardiologist. Restrict salt and fluid intake. Weigh daily. Smoking cessation counseling and resources given. Return to clinic in 2 months.

What Many Providers Do:

Assessment: Cough, CHF

		ICD-9	CMS Risk Score
Coding assignment:	Cough	786.2 -	0
	CHF	428.0-	.41
Demographic Score:			.44
Total RAF Score:			.85

What Does the Documentation say and how to appropriately document these diagnoses in the progress notes?



Assessment: Smokers Cough, CHF, Hypoxemia

		ICD9	CMS Risk Score
Correct Coding Assignment:	Smokers Cough	491.0 —	.399
	CHF-	428.0-	.41
	Hypoxemia	799.02—	.578
Demographic Score:			.44
Total RAF Score:			1.827

Risk Adjusted portion of the CMS premium is increasing to 100% based on what you are documenting today. Is your documentation sufficient to fund the care for your sicker members?