Top Diagnostic Documentation and Coding Opportunities

Complete and accurate documentation and coding of your patients' chronic and complex conditions is essential to clinical decision-making, continuity of care, and establishing the disease burden of your patient panel.

The LifeWise risk adjustment coding team regularly reviews medical records to validate the completeness and accuracy of diagnostic data sent to the U.S. Department of Health and Human Services (HHS) and the Centers for Medicaid and Medicare services (CMS) as required by the Affordable Care Act (ACA). LifeWise shares opportunities identified through this program with providers to support their efforts to improve quality of documentation and coding.

The yearly review of medical records results in the identification of several common provider Hierarchical Condition Category (HCC) coding opportunities. If you're interested in participating in future reviews to obtain results with examples and opportunities specific to your providers, training for your practice staff, or materials to support your training program, contact your Quality and Risk Adjustment Provider Clinical Consultant.

Overview

Top 4 HCC Coding Opportunities	1. Code to the highest specificity 2. Code all documented conditions 3. Avoid coding historical conditions as active 4. Support each submitted code with sufficient documentation

Opportunities

Opportunity #1 **Code to the highest specificity**	**Best Practice:** It's essential to select the most specific code that accurately describes the patient's condition. ICD-10 includes a wide range of highly specific codes for different diseases, many of which may not be included in quick pick lists or dropdowns in your Electronic Health Record (EHR) system. Ensure you have access to the full range of potential codes so that you're able choose the most accurate code for claim submission.		
	Documentation examples:	**What was coded:**	**What needs to be coded:**

	"Asthma: Well treated with her inhaled steroid"	J45.31 Mild persistent asthma with acute exacerbation	J45.909 Unspecified asthma, uncomplicated
	"Type 1 diabetes: Diabetes is moderate in severity, associated with hyperglycemia… A1c remains above goal."	E10.9 Type 1 diabetes mellitus without complications	E10.65 Type 1 diabetes mellitus with hyperglycemia

Opportunity #2 **Code all documented conditions**	**Best Practice:** ICD-10 guidelines require coding of all documented conditions that coexist at the time of the encounter and that require or affect patient care treatment or management. If a condition being managed by another provider affects your medical decision making during the encounter, it should be documented and coded. Coding of all documented conditions paints a complete picture of the complexity of your patient's health status.		
	Documentation examples:	**What needs to be coded:**	**Reason for opportunity:**
	"Suspicious of influenza. Will start Tamiflu as he is HIV+ and on Odefsey that puts him at higher risk for complications."	Z21 Asymptomatic human immunodeficiency virus (HIV) infection status	Evaluating and treating
	"Bilateral elbow pain… cannot take anti-inflammatory medications due to being Crohn's."	K50.90 Crohn's disease, unspecified, without complications	Evaluating

Opportunity #3 **Avoid coding historical conditions as active**	**Best Practice:** ICD-10 guidelines prohibit coding of conditions that were previously treated and no longer exist. Historical codes may be used as secondary codes if the historical condition has an impact on current care or influences treatment. Neoplasms should only be coded as active if the patient is undergoing treatment or refused the treatment (reason for refusal must be documented). If the patient has a sequela (late effect) after the acute phase or after termination of an illness or injury, don't code that condition as active. Choose the code from the sequela section instead. Coding of sequela generally requires two codes: the condition or nature of the sequela followed by the sequela code.		
	Documentation examples:	**What was coded:**	**What needs to be coded:**
	"Superficial vein thrombophlebitis. Has completed Xarelto… No clinical evidence of persistent SVT."	I80.01 Phlebitis and thrombophlebitis of superficial vessels of right lower extremity	Z86.718 Personal history of other venous thrombosis and embolism

	"67-year-old female who presents for evaluation of her chronic pain. She is an ovarian cancer survivor. Previous consultations include ortho for knee and oncology for past hx of cancer."	C56.9 Malignant neoplasm of unspecified ovary	Z85.43 – Personal history of malignant neoplasm of ovary Documentation does not include current treatment for ovarian cancer.

Opportunity #4 **Support each submitted code with sufficient documentation**	**Best Practice:** Each submitted code must be supported by documentation of the condition having been monitored, evaluated, assessed, and/or treated (MEAT) in the medical record.		
	Documentation examples:	**What was coded:**	**Reason for opportunity:**
	"Symptoms and Concerns: …suicidal ideation. Patient denies intent or plan of suicide."	T14.91XA Suicide attempt, initial encounter	No documentation of the attempt, only ideation.
	"With regard to the chronic cough… she does not have any related health problems, in particular… asthma…"	J45.991 Chronic variant asthma	Documentation only supports chronic cough, which would be coded with R05.