

QUALITY+

Risk Adjustment Program

MEDICARE ADVANTAGE



Guide to Documentation

The following tips can help ensure accurate medical coding and billing compliance for Medicare risk adjustment. These are based on the Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage plans and American Hospital Association (AHA) Coding Clinic™ guidelines.

State the diagnosis

Under International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) guidelines, a diagnosis can only be coded if it is stated in the documentation for the current visit.

Chronic conditions must be restated each time they are monitored, evaluated, assessed or treated. Medications and the corresponding diagnosis should be clearly linked in the documentation.

Documentation must be explicit. Assessing the signs, symptoms or findings related to a disease is not enough (e.g., “Fasting Blood Sugar 300” cannot be coded as uncontrolled diabetes).

Create a clear relationship to the diagnosis

Causal relationships should be stated, not inferred. Use phrases such as “due to,” “because of” or “related to” to establish a clear relationship. “With” does not always establish cause, except in the case of diabetes with neuropathy.

Include conditions and health status

Under ICD-10-CM guidelines, a condition exists only when it is stated. Frequently overlooked, but significant conditions include:

- Angina Pectoris
- Drug/Alcohol Abuse
- CHF
- Heart Arrhythmias
- COPD
- Morbid Obesity
- Depression
- Rheumatoid Arthritis
- Diabetes
- Vascular Disease

Certain health status codes are very important to assess, document and code at least annually, using the highest level of specificity:

- Patients undergoing dialysis (Z99.2)
- Lower limb amputation status (Z89.4X – Z89.9)
- Asymptomatic HIV status (Z21)
- Ostomy (specify SITE) (V93.X)

Remember to document permanent diagnoses as often as they are assessed or treated, or when they are a consideration in the patient’s care.

Signing off

Stamped signatures are not accepted.

- A typed signature alone does not meet the CMS signature requirement. Examples:
 - “Dictated by: John Doctor, MD”
 - “Dictated but not read” records also must be properly authenticated by the provider.
- Transcribed records must be either electronically or hand signed including date.
- Electronic signatures must be stated as “authenticated by,” “signed by” or “approved by” and include the date, name and credentials of the authoring/authenticating provider.

Use “History of” only when appropriate

Under ICD-10-CM guidelines, the term “history of” means the patient no longer has the condition. Do not use this term to describe a disease or condition that the patient is managing or you are monitoring. Frequently seen examples:

- History of congestive heart failure to indicate compensated congestive heart failure
- History of atrial fibrillation to indicate atrial fibrillation controlled by medication

Note: As an exception, always document when the patient has a history of a myocardial infarction (I25.2), and the approximate date of the myocardial infarction.

Additional Resources: For more information related to risk adjustment, visit the Centers for Medicare & Medicaid Services website at <http://csscooperations.com>. For more information related to Medicare Advantage, see the BlueCross BlueShield of Tennessee Provider Administration Manual at <http://www.bcbst.com/providers/manuals/bcbstPAM.pdf>. This information is not intended to be and should not be relied upon as legal, financial or compliance advice. Consult your own attorney or other appropriate professional for such advice.

Oncology: malignancy reminders

Malignancies should be documented only when the patient has evidence of current disease. If the disease has been eradicated through surgical intervention, radiation therapies or chemotherapy, then include a “history of” code.

- Patients who do not receive definitive treatment for their malignancy should continue to be coded with the malignancy diagnosis.
- Breast and prostate cancer patients on adjuvant therapy should be coded as if they have an active disease.

Stroke reminders

Because a cerebrovascular accident (CVA) is an acute event, it should not be documented as an active diagnosis for prolonged periods of time. Once the patient has been discharged from the hospital following a stroke, it should be documented and coded as a “history of” CVA without residual deficits, if none are present. The sequelae should be documented and coded every time they are assessed.

Other tips

- Use only standard medical abbreviations.
- Ensure the medical record is complete and legible.
- Record the patient’s name, date of birth and date of service on each page of his or her chart.
- Use subjective, objective, assessment and plan (SOAP) note format when applicable.

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ICD-10-CM is the International Classification of Diseases, Tenth Revision Clinical Modification.

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