BlueCross BlueShield of Alabama

Documentation & Coding Guidance

KEY POINTS:

- Any condition that is taken into account or affects patient care, treatment or management at the time of the encounter should be documented and coded. The condition must be documented as current to capture in coding.
- Documentation must support the code used.
- It's important to document and code the patient's diagnosis to the highest level of specificity.
- Some medical conditions never go away; however, coding from past medical history without current support for the condition is not acceptable. Be sure to review and update the past medical history, current problem list, and medication list at every visit.
- Diagnosed conditions must be expressly stated. Avoid terms such as probable, suspected, rule out or working diagnosis.
- All conditions should be documented at least annually.

The importance of consistent, complete documentation in a medical record cannot be overemphasized. Without it, accurate coding cannot be achieved and audit findings cannot be validated.

The federal government reimburses Medicare Advantage plans based on the health of their patients. This reimbursement is determined through a method used by CMS called risk adjustment.

Providers play an important role in the risk adjustment process because data from patient claims is used to indicate the complete picture of health for plan members.

This same data also enables Blue Cross and Blue Shield of Alabama to analyze and design programs to help manage patients' chronic conditions.

Documentation and coding must mirror one another in order to accurately capture the patient's complete picture of health.

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Thoroughly reviewing documentation and coding practices through internal auditing procedures ensures that the data has been reported correctly and that the appropriate reimbursement is received.

Best Medical Record

For a patient record to be considered a Best Medical Record by CMS, it should include:

- ☑ The provider's signature, credentials and date
- ☑ The patient's name and date of service on each page of the chart
- ☑ The medical record must support all diagnoses coded for the date of service submitted
- ☑ The record must be complete, legible, and able to stand alone
- ☑ One of the following designations should precede the practitioner's name for electronic records: *electronically signed by, authenticated by, signed by, approved by, validated by*

Best Practices

- Thoroughly reviewing documentation and coding practices through internal auditing procedures ensures that the data has been reported correctly and that the appropriate reimbursement is received.
- Telehealth visits need to state that the encounter was completed via audio *and* video in order to capture risk.
- Significant conditions such as transplant status, current ostomies, amputations, dialysis status, long-term insulin use, and asymptomatic HIV infection are frequently overlooked.

Resources:

- Common HCC ICD-10 Codes
- Risk Coding Corner

If you have questions related to chronic condition diagnosis coding, please contact maprovsupport@bcbsal.org

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