Blue Advantage
A Medicare Approved PPO

Documentation & Coding Guidance

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

KEY POINTS FOR BEST PRACTICES:

- Any condition that affects patient care, treatment or management at the time of the encounter must be documented as current to capture in coding.
- Documentation must support the code(s) used.
- Code all active, chronic conditions at least annually.
- When coding from past medical history or problem lists, use professional coding judgment and caution.
- Avoid using terms such as probable, suspected, rule out or working diagnosis when documenting active conditions.
- Diagnoses must be confirmed by the provider for the diagnosis code to be assigned appropriately.
- Code the diagnosis to the highest specificity with supportive documentation (e.g., N189 Chronic kidney disease, unspecified vs. N182 Chronic kidney disease, stage 2 [mild]).
- Remember to review and update the past medical history, current problem list and medication list at every visit.
- Telehealth visits must state the encounter was completed via audio and video in order to capture risk.

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

Consistent and complete documentation enables Blue Cross to analyze and design programs to help manage patients' chronic conditions.

The federal government reimburses Medicare Advantage plans based on their patients' health, and CMS determines this reimbursement using a method called risk adjustment.

Risk adjustment is a process of collecting all diagnosis codes for patients and using the documented illnesses, comorbidities and complications to determine a risk score.

The risk score is a ratio that represents the expected cost of care for each enrollee relative to the cost of the average Medicare beneficiary. More accurate data means a more accurate risk score.

With the new interactive Patient Health Snapshot and automated Health Risk 360 (AutoHR360) on *ProviderAccess*, health information can be reviewed at each visit. These enhancements help provide a complete picture of your patients' health.

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

What Is a Best Medical Record?

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

- ☑ Include the provider's signature, credentials and date
- ☑ Include the patient's name and date of service on each page of the chart
- ☑ Support all diagnoses coded for the date of service submitted
- ☑ Be complete, legible and able to stand alone

What Are Acceptable EMR Signatures?

Electronic credentials must be in one of the forms listed below.

- Accepted by
- Authenticated by
- Authored by
- Authorized by
- Closed by
- Completed by
- Confirmed by
- Digital signature: Provider Name, Credentials
- Digitized signature: Handwritten and scanned into the computer
- Electronically approved by
- Electronically signed by
- Finalized by
- Released by
- Reviewed by
- Signature derived from controlled access password
- Signed: Provider Name, Credentials
- Signed before import by
- Signed by
- Signed
- This is an electronically verified report by Provider Name, Credentials
- Verified by

Resources:

- Common HCC ICD-10 Codes
- If you have questions related to chronic condition diagnosis coding, please contact MAProvSupport@bcbsal.org

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For additional information, go to:
AlabamaBlue.com/Providers/CodingCorner

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

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