Closing Gaps & Meeting Metrics

Coding Tips & Best Practices

December 2022

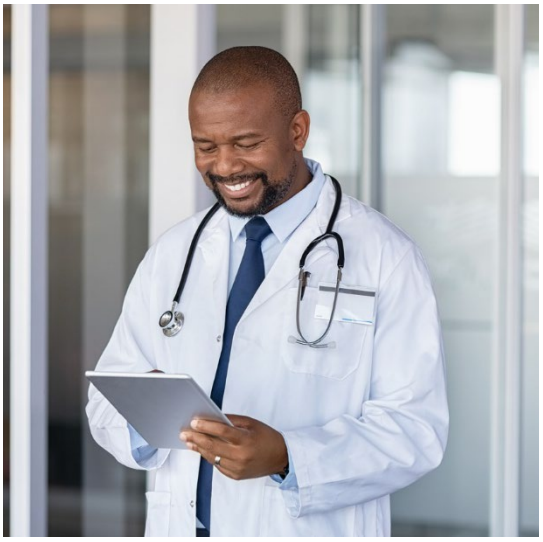
Best Documentation Practices for ICD-10 Coding

The *Evaluation and Management Services Guide* issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

> "Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation helps physicians and other healthcare professionals evaluate and plan the patient's immediate treatment and monitor the patient's healthcare over time."

Medical record documentation of patient diagnoses that is clear and concise with the highest level of specificity facilitates:

- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely healthcare provider payment for furnished services



Precise and accurate coding paints a picture and creates a summary of the disease burden of each patient. That health summary is then submitted to CMS in the form of ICD-10 codes which determine the patients' risk score and eventual funding for their healthcare and resource utilization in the upcoming year.

This means providers should code all documented conditions that coexist at the time of the encounter and require or affect patient care, treatment, or management. This must be documented by the provider and cannot be inferred by coders.

In value-based care, the focus shifts from submitting codes for reimbursement to submitting codes to support the care you are delivering to each member of the health plan. It is imperative to paint the picture of each patient in your practice with accurate and specific ICD-10 codes, along with thorough documentation that leads to accurate coding.

'MEAT'

One way to document chronic conditions is by using the acronym MEAT. Items to include in documentation include the following:

M – Monitor
- Symptoms
- Disease progression or regression
- Tests ordered
- References to lab results and/or other tests

E – Evaluate
- Test results
- Medication effectiveness
- Response to treatment
- Physical exam findings

A – Assess/Address
- Discussion, records review
- Counseling
- Acknowledgment
- Documentation of status and level of condition

T – Treat
- New prescriptions or continuation of medications
- Surgical and/or other therapeutic interventions
- Referral to specialist for treatment or consultation
- Plan for condition management

MEAT Documentation Examples

Condition	Documentation Examples
Congestive heart failure	Stable at this time. Will continue same dose of Lasix and ACE inhibitor.
Abdominal aortic aneurysm	Abdominal ultrasound ordered.
Major depression	Continued feelings of hopelessness despite increase in Zoloft. Will refer to psychiatrist for further management.
Hypercholesterolemia and Chronic hepatitis C	Prescribing Zetia for hypercholesterolemia as it won't adversely affect the liver as patient suffers from chronic Hepatitis C.
Type 2 DM	Blood Sugar log and A1c results reviewed with patient. Continue medication as is with no changes at this time
GERD	No complaints. Symptoms controlled on meds.
Peripheral neuropathy	Decreased sensation of BLE by monofilament test.
Ulcerative colitis	Currently managed by Dr. X.
Morbid obesity	Advised patient to monitor calorie intake and increase activity level.
Decubitus ulcer of heel	Wound measurement, currently being followed by wound care.

Document All Conditions

Document and code all conditions that exist at the time of the encounter.

- Include any condition(s) that affects the care or management of the patient's needs. This includes conditions managed by a specialist but affect your decision-making (e.g., diabetes, atrial fibrillation, COPD, multiple sclerosis, hemiplegia, rheumatoid arthritis, Parkinson's disease, etc.).
- Document and code all complications and comorbidities, and use linking terms such as "because of," "related to," or "associated with."
- Update your problem list with current active conditions. Remove inactivate conditions that no longer exist.
- Documentation must support the presence of your diagnosis codes and indicate your assessment and plan for the management of each code along with the medication used to treat as necessary. This may be as simple as using words such as "stable, continue medications," "managed by oncology," or "diet and exercise discussed."
- For each coded condition include at least one component of MEAT in your assessment and plan.
- Ensure there is no conflicting documentation. HPI notes need to support the chosen ICD-10 codes (e.g., HPI states "no diabetic complications," but ICD-10 E11.42 code "Diabetes type II with polyneuropathy" is used).
- Code all conditions to the highest specificity. You may need to defer to a specialist's diagnosis, since they may have a better understanding of the disease process for the specific condition.
- Be aware of unspecified codes since there is usually an opportunity to utilize a code that will more accurately describe a condition – ultimately resulting in improved reimbursement.
- Remember to include common status codes (permanent conditions) such as amputations, transplant status, ostomies, etc.

Additional Tips for Documenting Chronic Conditions

Document each patient encounter as if it is the only encounter.

- Assign codes for every condition documented with evidence of MEAT, not just the condition for which the patient came in.
- Code all chronic and complex conditions on an annual basis.
  - Review and document conditions managed by a specialist.
  - This counts as MEAT and can be coded on the claim.
- Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "History of."
- Avoid using the words "History of" for a condition that is chronic but currently stable, such as COPD, DM, or atrial fibrillation.
- When seeing a patient who comes in infrequently, ensure that chronic conditions are reviewed at the visit, even if the patient is only presenting for an acute issue.
- Specify the basis for ordering additional testing and/or treatment.
- Show patient's progress or lack of progress.
- If refills are made outside of a visit, encourage the patient to schedule a checkup so the condition can be reviewed and managed at least once a year.

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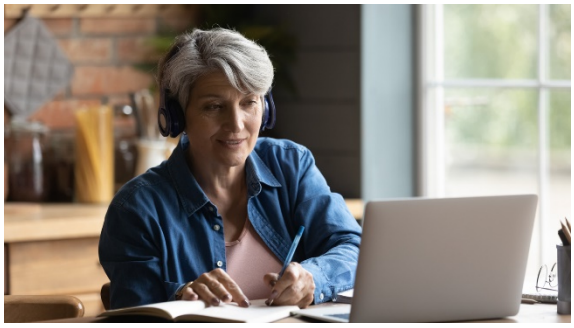

We offer live and on-demand webinars that provide detail about how to support diagnoses per Centers for Medicare & Medicaid Services and U.S. Department of Health and Human Services guidelines. These courses are updated with current codes and guidelines and are eligible for 1.5 continuing education unit credits each.

Topics include:

- Atrial fibrillation
- Cancer
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Diabetes
- Major depression
- Mental health
- Rheumatoid arthritis

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References

- *CMS.gov*
- *AAPC*
- *AHIMA documentation and coding*
- *ICD-10-CM coding guidelines*

[1] Availity LLC is a multi-payer joint venture company.