EmblemHealth®

A GUIDE TO DOCUMENTATION AND CODING

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Why is it important for medical record documentation to be complete, accurate and consistent with the care provided? Without it, the wrong codes can be assigned, the wrong diagnoses and procedures reported, and resources for patient care misallocated. The better the documentation, the more we can help ensure the best outcomes for your patients, our members.

This guide highlights the basics of documentation, coding and medical record reviews. It includes strategies for improving your documentation and coding systems. If you have any questions about the information, please contact us through our Message Center by signing in to our secure provider Web site at **www.emblemhealth.com**. You can also e-mail us directly at **govtprogramsinfo@emblemhealth.com**.

KEY TERMS

Following is a quick reference to key components of medical record documentation:

Documentation

Clinical documentation is the foundation of every patient health record. It has a significant impact on patient care, care coordination, coding, billing and compliance. It is also:

- The key determinant of the quality of care a patient received
- The primary tool clinicians use to communicate about a patient
- Evidence that the care billed for was rendered to the patient
- Data we rely on for strategic planning, internal research and to identify case, care or disease management opportunities

Coding

Coding is the art of translating clinical documentation into uniform diagnostic and procedural data sets. This data is used to determine quality indicators, morbidity and mortality, resource consumption, physician profiles and clinical outcomes, as well as to identify patients most in need of case management or disease management services. Complete and accurate clinical documentation is essential to ensuring codes are correctly assigned. For official coding guidelines, refer to **www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf**.

CMS DRG and HCC Systems

The Centers for Medicare & Medicaid Services (CMS) has systems in place to calculate the resources needed to support the medical condition of or procedure provided to a Medicare Advantage patient. They first use the CMS Diagnosis-Related Group (DRG) system. Next they use the CMS Hierarchical Chronic Conditions (HCC) system.

On April 1, 2013, CMS stated the following about the critical importance of well-maintained medical records:

> CMS understands the clinical value of disease and care management programs in targeting conditions early and preventing or slowing the progression of disease, improving the health of beneficiaries, and potentially saving health care costs. The goal of risk-adjusted payments is to pay accurately using the appropriate relative risk for a beneficiary. **This requires supportive documentation and coding to accurately describe the patient's health status to the highest level of specificity**.

CMS REQUIREMENTS FOR MEDICAL RECORD DOCUMENTATION

To ensure patients' health statuses are correctly represented, CMS has specific requirements for what information to document, as well as how and when to record it:

Information That Must Be Documented

Documentation for each patient encounter must include the reason for the visit (chief complaint); any relevant medical history, exam findings, prior diagnostic test results, assessment results, clinical impressions and diagnoses; and the plan of care.

Conditions and Procedures That Must Be Documented at Least Once a Year

- Active status codes (e.g., amputation, ostomies, kidney transplant)
- Chronic conditions (e.g., CHF, COPD, DM, A-Fib)
- Conditions that affect ADLs (e.g., history of CVA with hemiplegia)
- Pertinent past conditions (e.g., old MI)
- All conditions that require medication (e.g., major depression, RA)

How Information Must Be Documented

CMS requires that medical record documentation for our members:

- Be legible
- Include a practitioner's signature and credentials
- Identify the patient and date of service
- Support all diagnoses coded
- Document the patient's progress and treatment results
- Justify the treatment and level of care
- Use only standard abbreviations (keep to a minimum)
- Promote continuity of care among practitioners

Legible Handwriting

Illegible documentation can lead to incorrect diagnoses, medical errors and unclear communication between clinical and professional staff. It can also result in denial of payment for services.

Acceptable Signatures and Credentials

CMS requires practitioners to authenticate each note for services provided by including their signature and credentials. The charts that follow specify acceptable and unacceptable formats for signatures and credentials:

ACCEPTABLE PRACTITIONER SIGNATURES AND CREDENTIALS	
Type	**Acceptable**
Handwritten signature or initials, including credentials	Mary C. Smith, MD or John J. Smith, DO
Signature stamp, including credentials	Must comply with state regulations for signature stamp authorization
Electronic signature, including credentials	Requires authentication by the responsible provider (e.g., "Approved by," "Signed by," "Electronically signed by") Must be password protected and used exclusively by the individual practitioner

UNACCEPTABLE PRACTITIONER SIGNATURES AND CREDENTIALS	
Type	**Unacceptable Unless**
Typed name	Authenticated by the practitioner
Non-practitioner or non-practitioner extender (e.g., medical student)	Co-signed by acceptable practitioner
Signature but no credentials of service practitioner	Practitioner creditionals appear on practitioner stationery

DOCUMENTATION AND CODING TIPS

Here are some common issues and misused language in medical record documentation and coding, as well as tips for enhancing your practice's medical records:

Common Issues With Documentation

- **The diagnosis isn't specific enough**. A more specific diagnosis than the one documented appears to be supported (e.g., bronchitis is documented when the condition appears to be COPD with chronic bronchitis).
- **The condition being treated isn't documented**. Treatment was provided without documentation of the condition that is being treated (e.g., digoxin or Lasix were prescribed without CHF being documented).
- **Diagnostic test results are documented but unsupported**. Test results are reported without the clinician's clinical impression or the significance of the results (e.g., GRF was documented, so does the patient have CKD?). Reporting test results is just one part of the diagnostic process. The practitioner must also document the clinical implications of a diagnosis so the coder can assign it the precise ICD-9 code.
- **Missing or illegible information**. Medical records often include illegible progress notes, faulty provider signatures and missing credentials. See the above section "How Information Must Be Documented."

Language To Use and Avoid

- **Be specific, when possible**. CMS allocates resources based on the severity of a member's illness over many years. Since there are different codes for different gradations of a condition, it's important to select the code that most precisely describes the condition or procedure being reported.

IF THEY HAVE THIS CONDITION…	USE THIS CODE…	NOT THIS CODE…
Major depression	Major depression 296.2x or 296.3x	Depression, NOS 311
Chronic bronchitis	Chronic bronchitis 491.9	Bronchitis 490

- **Be careful stating "history of" when the condition is acute or chronic**. Since "history of" means the patient no longer has the condition, avoid statements such as "patient is here for history of HTN, A-Fib and DM." Rather, state: "patient is here for follow-up of their HTN, A-Fib and DM." Then expand on the current status and treatment plan for these conditions.
- **Rule out possible conditions**. Don't code a questionable diagnosis in the outpatient setting. Instead, code the signs and symptoms until a definitive diagnosis can be determined.

Medical Record Review Process

You may be contacted by our vendor, Inovalon (formerly MedAssurant), to arrange a convenient way of obtaining copies of medical records for some of our plan members. If Inovalon does contact you, **it is very important you comply with this medical record request in a timely manner**.

CMS and the New York State Department of Health (NYSDOH) require EmblemHealth to conduct medical record reviews of our members. These reviews ensure we have the documentation needed to clarify specific medical conditions for these members. They also help us determine which members could benefit from enrollment in our customized disease management programs.

We appreciate your help collecting these records as we work to meet and exceed CMS/NYSDOH requirements for claims and encounter data submission.

Physician Office Protocol for Blood Pressure Readings

Blood pressure reading is one of the most inaccurately performed measurements in clinical medicine. The measurements can be affected by body or arm position, differences between arms, and blood pressure cuff size and placement. Below are recommended guidelines from the American Heart Association (AHA) for In-Office Setting Blood Pressure Measurement:

- Patient should be seated comfortably, with back supported, legs uncrossed and upper arm bared.
- Patient's arm should be supported at heart level.
- Cuff bladder should encircle 80 percent or more of the patient's arm circumference. Mercury column should be deflated at 2 to 3 mm per second.
- The first and last audible sounds should be recorded as systolic and diastolic pressure, respectively. Measurements should be given to the nearest 2 mm Hg.
- Neither the patient nor the person taking the measurement should talk during the procedure.

Classification of Hypertension

CLASSIFICATION	Blood pressure (mm Hg)	
	Systolic	**Diastolic**
Normal	119 or lower	79 or lower
Prehypertension	120 to 139	80 to 89
Stage 1 hypertension	140 to 159	90 to 99
Stage 2 hypertension	160 or higher	100 or higher

It is widely recognized that multiple blood pressure determinations have greater predictive power than a single office reading. The AHA therefore recommends that at least two readings be taken, with a one-minute interval between them and the average of the measurements recorded. The first reading in a series is usually the highest. Additional readings should be taken if the difference between the first two is greater than 5mm Hg.[1]

[1]American Family Physician. 2005. "New AHA Recommendations for Blood Pressure Measurement." **http://www.aafp.org/afp/2005/1001/p1391.html**.

2014 CMS MODEL CHANGES

CMS has revised its Hierarchical Chronic Conditions (HCC) model for 2014, changing current codes and adding new ones. Below is a summary of the changes for 2014:

- Revisions to the HCC groupings.
- Renumbering the HCCs so they are listed in a logical order and so that similar categories of HCCs are grouped together.
- An increase to 79 HCCs, up from 70 HCCs in 2013. (This increase is a result of both the newly added HCCs and the division of several existing HCCs.)
  - — 225 new ICD-9 codes were **added**. They are from 14 different CMS-HCC categories.
  - — 134 ICD-9 codes were **dropped**. They are from 11 different CMS-HCC categories.

To review the Medicare Risk Adjustment Model, visit the CMS Web site at **www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html**.

2014 ICD-9 CODES

Following are highlights of the new and notable ICD-9 codes for the 2014 CMS-HCC model.

Morbid obesity and other significant endocrine and metabolic disorders are new to the 2014 CMS-HCC model:

MORBID OBESITY 278.01

For the body mass index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified health care practitioner legally accountable for establishing the patient's diagnosis). This is because this information is typically documented by other clinicians involved in the care of the patient; for example, a dietitian often documents the BMI and nurses often document the pressure ulcer stages. However, the associated diagnosis(es) — such as obesity, morbid obesity or pressure ulcer — **must be documented by the patient's provider**.

Morbid obesity defined as BMI 40 or greater V85.41–V85.45*

V85.41 BMI 40.0–44.9, adult

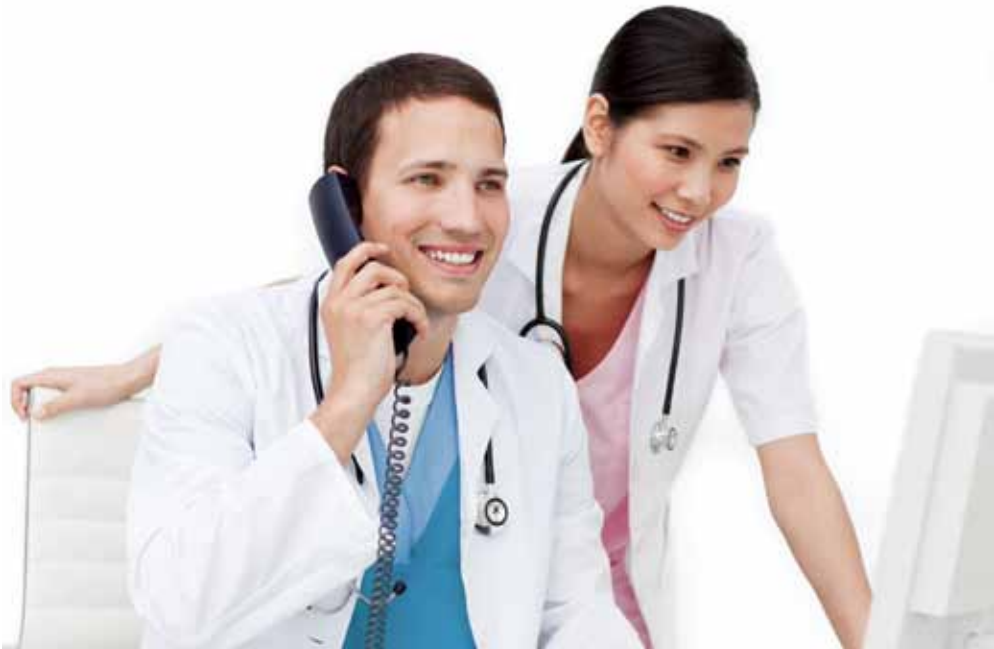
V85.42 BMI 45.0–49.9, adult

V85.43 BMI 50.0–59.9, adult

V85.44 BMI 60.0–69.9, adult

V85.45 BMI 70.0 and over, adult

*Code first the morbid obesity 278.01.



The BMI and pressure ulcer stage codes should only be reported as secondary diagnoses. This means that the provider must document and code morbid obesity or pressure ulcer first; then the BMI code can be added to provide clinical significance.

In addition to documenting and coding the pressure ulcer, the clinician must also code the stage of the ulcer to show severity. Below are the stages of pressure ulcers. Stages III and IV both risk adjust.

- 707.20 Pressure ulcer, unspecified stage
  Healing pressure ulcer, NOS or unspecified stage
- 707.21 Pressure ulcer stage I
  Pressure pre-ulcer skin changes limited to persistent focal erythema
- 707.22 Pressure ulcer stage II
  Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
- 707.23 Pressure ulcer stage III
  Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue
- 707.24 Pressure ulcer stage IV
  Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon or bone

EXUDATIVE MACULAR DEGENERATION

362.52 Exudative macular degeneration is new to the CMS-HCC model. It includes macular degeneration, documented as disciform macular degeneration or wet macular degeneration.

FIBROSIS OF THE LUNG AND OTHER CHRONIC LUNG DISORDER

These are new to the CMS-HCC model for the 2014 payment year. Hypoxemia was removed; therefore, you need to document the specificity or reason for the hypoxemia.

CHRONIC KIDNEY DISEASE

Beginning in the 2014 payment year, CKD 1-3, unspecified renal failure and nephritis are all excluded from the CMS-HCC model.

STAGE IV, V AND ESRD RISK ADJUST TO THE CMS MODEL

Continue to document the stage of CKD, to indicate severity. The lower stages will fall into the lower RX-HCC model.

CODE	STAGE	GLOMERULAR FILTRATION RATE	DESCRIPTION
585.1	1	90+	Normal kidney function, but urine or other abnormalities point to kidney disease
585.2	2	60–89	Mildly reduced kidney function, urine or other abnormalities point to kidney disease
585.3	3	30–59	Moderately reduced kidney function
585.4	4	15–29	Severely reduced kidney function
585.5	5	14 or less	Very severe or end-stage kidney failure (established renal failure)

Following are some of the common diagnoses added to the 2014 model:

CODE	DESCRIPTION
135	Sarcoidosis Manifestations of sarcoidosis are reported in addition to the infection.
238.4	Polycythemia vera
238.7[1]	Essential thrombocythemia
238.76[1]	Myelofibrosis with myeloid metaplasia
238.77[2]	Post-transplant lymphoproliferative disorder
238.79	Lymphatic/hematopoietic tissues NEC

[1]ICD-9-CM classifies myeloproliferative disorders and myelodysplastic syndromes as "other specified" neoplasms of uncertain behavior of lymphatic and hematopoietic tissues, even though they are recognized as hematological malignancies.

[2]Post-transplant lymphoproliferative disorder will most likely be sequenced as a secondary diagnosis with a code from 996.8. Complications of a transplanted organ is the first listed diagnosis.

CODE	DESCRIPTION
251.0	Hypoglycemic coma Excludes: Hypoglycemic coma in diabetes mellitus and iatrogenic hyperinsulinism
252.00	Hyperparathyroidism NOS
252.01	Primary hyperparathyroid
252.02[3]	Secondary hyperparathyroidism **non-renal**
252.08	Other hyperparathyroidism
252.1	Hypoparathyroidism
252.8	Other specified disorders of parathyroid gland
252.9	Unspecified disorder of parathyroid gland

[3]252.02 Do not use for hyperparathyroidism from renal causes.

CODE	DESCRIPTION
253.7[4]	Iatrogenic pituitary disorders
253.8[5]	Other disorders of the pituitary
253.9	Pituitary disorder NOS

[4]253.7 Includes: Hypopituitarism that is hormone-induced, hypophysectomy-induced, postablative and radiotherapy-induced.

[5]253.8 Includes: Abscess of pituitary, adiposogenital dystrophy, cyst of Rathke's pouch and Frohlich's syndrome.

CODE	DESCRIPTION
255.0[6]	Cushing's syndrome
255.10	Hyperaldosteronism NOS

[6]255.0 Includes a secondary form of Cushing's syndrome from a drug.

CODE	DESCRIPTION
255.41[7]	Glucocorticoid deficient
255.42[8]	Mineralocorticoid deficiency
255.5	Other adrenal hypofunction

[7]255.41 Includes: Adrenal disorders such as atrophy, calcification, crisis, hemorrhage, infarction and insufficiency. Also includes combined glucocorticoid and mineralocorticoid deficiencies.

[8]255.42 Includes: Hypoaldosteronism.

CODE	DESCRIPTION
255.5	Adrenal medullary insufficiency
273.4	Alpha-1-antitrypsin deficiency
273.4	AAT deficiency
278.01[9]	Morbid obesity (BMI 40 or greater)
278.03	Obesity hypoventilation syndrome

[9]278.01 Includes: Pickwickian syndrome.

Use additional codes to identify BMI, if known, on both 278.01 and 278.03 or any other code that impacts care.

CODE	DESCRIPTION
V85.41	BMI 40.0–44.9, adult
V85.42	BMI 45.0–49.9, adult
V85.43	BMI 50.0–59.9, adult
V85.44	BMI 60.0–69.9, adult
V85.45	BMI 70 and over, adult
282.43[10]	Alpha thalassemia
282.44[10]	Beta thalassemia
282.45[10]	Delta-beta thalassemia
282.47[10]	Hgb E-beta thalassemia
282.49	Other thalassemia

[10]These were new 2012 ICD-9 codes effective October 1, 2011. Before October 1, 2011, a single ICD-9 code (242.49) captured all non-sickle cell–related thalassemias. This one code included the entire spectrum, from asymptomatic patients (silent carrier or thalassemia trait) to patients with severe disease.

CODE	DESCRIPTION
282.5	Sickle-cell trait
282.7	Other hemoglobinopathies Includes: Abnormal hemoglobin, NOS
286.9	Coagulation defects NEC/NOS Includes: Defective coagulation, NOS, deficiency coagulation factor NOS, delay coagulation and disorder of coagulation and hemostasis

CODE	DESCRIPTION
287.0	Allergic purpura Excludes: 287.39 Hemorrhagic pupura and 709.1 Purpura annularis telangiectodes
287.1	Thrombocytopathy
287.2	Purpura NOS
287.30	Primary thrombocytopenia NOS
287.31	Immune thrombocytopenic purpura
287.33	Congenital/hereditary thrombocytopenic purpura
287.39	Primary thrombocytopenia NEC
287.5	Thrombocytopenia NOS
287.8	Hemorrhagic conditions NEC
287.9	Hemorrhagic conditions NOS

Excluded from 287 rubic are 238.79 Hemorrhagic thrombocythemia and 286.6 Purpura fulminans.

CODE	DESCRIPTION
289.81	Primary hypercoagulable state
289.82	Secondary hypercoagulable state
289.83	Myelofibrosis

Documentation must be specific for accurate code assignment. 282.82 excludes heparin-induced thrombocytopenia (HIT) 289.84.

CODE	DESCRIPTION
362.01	Diabetic retinopathy NOS
362.03	Nonproliferative diabetic retinopathy NOS
362.04	Mild nonproliferative diabetic retinopathy
362.05	Moderate nonproliferative diabetic retinopathy
362.06	Severe nonproliferative diabetic retinopathy
362.07	Diabetic macular edema*

Code first diabetes (250.5x or 249.5x).

*Code 362.07 must be used with a code for diabetic retinopathy (362.01–362.060).

CODE	DESCRIPTION
362.52	Exudative macular degeneration Includes: Kuhnt-junius degeneration, senile macular degeneration both disciform and wet
366.41	Diabetic cataract

Code first diabetes (250.5x-249.5x).

CODE	DESCRIPTION
398.91	Rheumatic heart failure Includes: Congestive rheumatic heart failure and rheumatic left ventricular failure
454.0	Varicose veins of lower extremity with ulcer
454.2	Varicose veins of lower extremity with ulcer and inflammation
494.0	Bronchiectasis w/o acute exacerbation
494.1	Bronchiectasis with acute exacerbation

Excluded from this 494 rubic is 748.61 Bronchiectasis as a congenital disorder and 011.5 Bronchiectasis in active tuberculosis.

CODE	DESCRIPTION
508.0	Acute pulmonary manifestations due to radiation
508.1	Chronic pulmonary manifestations due to radiation
508.2	Respiratory condition due to smoke inhalation (default code for smoke inhalation)
508.8	Respiratory condition due to other specific external agents
508.9	Respiratory condition due to unspecified external agent

Use additional code to identify the associated respiratory condition.

CODE	DESCRIPTION
516.30*	Idiopathic interstitial pneumonia
516.31*	Idiopathic pulmonary fibrosis
516.32*	Idiopathic non-specific interstitial pneumonitis
516.33*	Acute interstitial pneumonitis

*These were new 2012 ICD-9 codes effective October 1, 2011. Before this code change on October 1, 2011, there was not a specific ICD-9 for IPF. It is also called cryptogenic fibrosing alveolitis, which was previously indexed to 516.3 Idiopathic fibrosing alveolitis. The course of IPF is quite different from interstitial pneumonias, including nonspecific interstitial pneumonia, the disease it is most commonly confused with.

CODE	DESCRIPTION
517.2	Lung involvement in systemic sclerosis
517.8	Lung involvement in other disease classified elsewhere
517.2	Code first underlying disease 710.1
517.8	Code first underlying disease: 135, 277.3x, 710.0, 710.2, 710.4
518.3	Pulmonary eosinophilia Excludes: Pulmonary infiltrate, NOS 793.19

CODE	DESCRIPTION
995.90	SIRS, NOS
995.91	Sepsis
995.92	Severe sepsis
995.93	SIRS-non-infectious process w/o acute organ dysfunction
995.94	SIRS-non-infectious with acute organ dysfunction

Additional information regarding these codes:

CODE	DESCRIPTION
995.90	Code first underlying condition.
995.92	Code first underlying infection. Use additional code to specify acute organ dysfunction.
995.93	Code first underlying condition, such as acute pancreatitis 577.0 or trauma.
995.94	Code first underlying condition, such as acute pancreatitis 577.0, heat stroke 992.0 or trauma. Use additional code to specify organ dysfunction.

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