Top 10 Documentation & Coding Errors
Session Guidelines

This is a 15 minute webinar session for CNC physicians and staff

CNC holds webinars monthly to address topics related to risk adjustment documentation and coding

Next scheduled webinar:
  • September
  • Topic: ICD-10-CM Updates

CNC does not accept responsibility or liability for any adverse outcome from this training for any reason including undetected inaccuracy, opinion, and analysis that might prove erroneous or amended, or the coder/physician’s misunderstanding or misapplication of topics. Application of the information in this training does not imply or guarantee claims payment.
Clinical Documentation Improvement

Only accurate, consistent, and complete documentation can translate into the data and information necessary to ensure clinical quality, substantiate medical necessity, and determine the most appropriate reimbursement. No matter the setting, the health record documentation, as designated by the provider, remains the foundation upon which many decision are based. As a result, efforts to improve the quality of that documentation require on-going education.

It is a common trait among physicians that they think they care for the sickest patients. Proper documentation can help support or debunk that claim. Simple-good clinical documentation will improve communication, increase recognition of comorbid conditions that are responsive to treatment, validate the care that was provided, and show compliance with quality and safety guidelines.

WHY CLINICAL DOCUMENTATION IMPROVEMENT IS A QUALITY EFFORT

• Better recognition of patient comorbidities and severity of illness
• Improved patient outcomes
• Decreased risk of hospital admits
• Performance metrics-utilization of the severity of illness and risk of mortality
Top 10 Errors

Documentation and coding is an important process and must be accurate. Coding mistakes can lead to claim denials and financial take backs from insurance companies. We must take appropriate measures to ensure that we avoid mistakes.

1. Documentation does not indicate the diagnoses are being monitored, evaluated, assessed, or treated (MEAT).

   - **M** = Monitored
   - **E** = Evaluated
   - **A** = Assessed
   - **T** = Treated

![MEAT the Chronic Condition](image)
Coding conditions that are stated as “probable”, “suspected”, “questionable”, “rule out”, “working diagnosis”, or “resolved”.

**ICD-10-CM Guidelines for Outpatient:**

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

**Please note:** This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.
Top 10 Errors

3. Status of cancer is unclear or treatment is not documented. A note stating “follow-up with Oncology” is insufficient.

ICD-10-CM Guidelines:

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.

The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.
Failure to link complications, in the documentation, to the underlying etiology and failure to report manifestation codes.

**ICD-10-CM Guidelines:**

The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

The classification **presumes a causal relationship between the two conditions** linked by these terms in the Alphabetic Index or Tabular List.

These conditions **should be coded as related even in the absence of provider documentation explicitly linking them**, unless the documentation clearly states the conditions are unrelated.
Recent laboratory values, radiology findings, and consultation findings are not documented in the progress note to support diagnosis, e.g. the note may include:

- CXR 10/1/16 showed Atherosclerosis of Aorta
- BMP 10/1/16 showed GFR 27 CKD Stage IV
- Pulmonology note 10/1/16 reports Chronic Respiratory Failure
Top 10 Errors

6. Diagnosis codes are invalid or contain an inaccurate code description.
   1. Invalid Code E78.0 Pure Hypercholesterolemia (√ 5th )
      1. Valid Code E78.00 Pure Hypercholesterolemia, Unspecified
   2. Inaccurate Code Description I77.9 Carotid Artery Disease
      1. Accurate Code Description I77.9 Disorder of arteries and arterioles, unspecified
The highest degree of specificity was not assigned the most precise ICD-10 code to fully explain the narrative description of the symptom or diagnosis in the medical record.

**ICD-10-CM Guidelines:**

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
Top 10 Errors

8 Discrepancies found between the diagnoses being billed vs. the actual written description in the medical record.

**ICD-10-CM Guidelines:**

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported.

The importance of consistent, complete documentation in the medical record cannot be overemphasized.

Without such documentation accurate coding cannot be achieved.
The electronic health record was unauthenticated (NOT electronically signed with credentials and date).

**CMS Signature Guidelines:**

For a signature to be valid, the following criteria must be met:

- Services that are provided or ordered must be authenticated by the ordering practitioner
- Signatures are handwritten, electronic, or stamped (stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of inability to sign due to a disability)
- Signatures are legible

You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner’s signature is missing from the medical record, submit an attestation statement from the author of the medical record. Your contractor may offer specific guidance regarding addenda to medical records.
Top 10 Errors

10 Chronic conditions are not stated as such, (e.g. hepatitis or renal insufficiency), and they are not documented in the medical record at least once a year (e.g. s/p amputation right big toe).

**ICD-10-CM Guidelines:**

For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.
Questions

Please submit coding and documentation questions to RAFeeducation@cnchealthplan.com