AVOID CODING AND DOCUMENTATION POTHOLES

Your GPS won't highlight unexpected road closures or nasty potholes! Here's what to watch for as you head towards improved coding and documentation:

POTHOLE	HOW TO AVOID
Incorrect use of "history of"	State "active problems include..." and avoid using "history of" for a condition that is chronic but currently stable such as COPD, DM, or A-Fib.
Not updating active problem list	If a condition is no longer active, remove it from the list, move it to past medical history, or add "history of."
Incorrect documentation of cause and effect	Clearly document a causal link between the disease and the complication. Use "diabetic neuropathy" or "neuropathy due to diabetes" rather than "diabetes, neuropathy, etc..."
Conditions not documented as "chronic"	Sometimes chronic conditions are coded as acute or not specified. Consider the difference between unspecified viral hepatitis (B19.9) and chronic viral hepatitis (B18.2).
Not coding "status of"	You can list these under Active Problem List, and they don't need to be supported by evaluation or management documentation. Diagnoses that indicate status of amputations, ostomies, and solid organ transplants should be documented and reported on a claim annually.

FOUR DIAGNOSIS CODE LIMITATION

Road Closed Ahead. Local Traffic Only!

You may have the best documentation and coding practices around, but if your practice management system can't attach more than four diagnosis codes per CPT to a claim, you've got to find another route to ensure all documented diagnoses are reported.

In order to completely code a visit with a patient who has multiple chronic conditions, it's commonly necessary to need to assign more than four diagnosis codes to completely and accurately capture the work you've done and the complete story of your patient's health.

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USE MEAT TO SELECT YOUR DX CODES

Be on time to every MEATing by paying attention to signposts and mile markers in documentation!

If you monitored, evaluated, assessed or treated (MEAT) a condition in a visit and documented it, then the corresponding diagnosis code should be submitted on a claim. This gets you credit for managing comorbidities and other conditions, even if they weren't the chief complaint, and for the decision-making surrounding the primary diagnosis.

We all know that patient who asks for a medication refill as you're walking out of the exam room. Don't undervalue your work. It may have only taken seconds to do a checklist in your head to confirm a refill is appropriate. So, get credit by documenting, "diagnosis is stable, continue med, and follow up in X months."

CODE MENTAL HEALTH TO THE HIGHEST SPECIFICITY

Is your final destination on the left or the right? Is the building blue or green? Those little details can be the key to knowing you've arrived at the right location!

Say what you mean, especially when it comes to mental health assessments.

If you coded major depressive disorder (F32.9), could you have meant acute reaction to major stress with depressive Sx (F43.0)? Or, depressive states associated with stressful events (F34.0- F34.9)?

Mental health diagnoses are often undercoded by providers due to a lack of expertise or time with the patient to feel comfortable with the actual diagnosis, a patient's concern that a behavioral health diagnosis appears on their chart, and/or the diagnosis is sent to their insurance plan. We understand these concerns, but please do your best to be as specific as possible so that the patient is eligible for the resources that you know they need and deserve.

For more tips, visit **www.premera.com/wa/provider/commercial-risk-adjustment/**

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