“The Mechanics of Chart Documentation”

Documentation validates that services were provided, ensures continuity of care, supports medical necessity and verifies that services provided are reported with accuracy. Good documentation supports the level of service billed resulting in appropriate reimbursement.

* The physician’s signature and credentials must be on each chart entry.
* The patient name and the date of service must be on each page of the patient chart.
* The medical record must be complete and legible.
* Only standard medical abbreviations should be used.
* Use SOAP format when applicable.
* Note all acute and chronic diagnoses with the current status and treatment plans in the progress note.

ICD-9-CM Guidelines and Tips

* Current year version of ICD-9-CM 2008 must be used for accurate diagnostic coding.
* Superbills need to be managed, updated, expanded and revised yearly.
* Diagnosis codes must be accurate and specific. If a code offers 5 digits in ICD-9-CM, five digits must be used. Each digit adds specificity. Avoid unspecified codes .9 unless there is not a more specific code available. Code both the etiology (underlying disease) and the manifestation of the disease. The underlying disease would be coded first, with the manifestation of the disease in 2nd place.

Example: Kaposi’s sarcoma due to HIV
042 (HIV) underlying disease
176.0 Kaposi’s sarcoma (manifestation)

* When a combination code is offered in ICD-9-CM to classify two diagnoses, it must be used.

Example: Malignant Hypertensive Chronic Kidney Disease
Chronic Kidney Disease Stage V
403.01 Hypertensive chronic kidney disease, malignant, with ckd stage v or end stage renal disease
585.5 Chronic kidney disease, Stage V

Don’t Miss the Forest for the Trees!

Risk Adjustment coding requires that the “immediate” problem of the patient be evaluated and coded, in addition to all conditions that effect the “composite picture” of the health status of the Senior.

Consider this:

**Congestive Heart Failure** = HCC 80 = Factor .395 for Risk Adjustment

The patient status scenarios listed below have reimbursement and factor ratings anywhere from approximately equal to - 4 times higher than Congestive Heart Failure. There are only five patient status categories listed below that have a lower factor than Congestive Heart Failure. These coding opportunities are too important to miss.

1. **Is the patient on Renal Dialysis?**
   Category ICD-9 V45.1
   HCC 130
   Factor 1.432

2. **Does the patient have tracheostomy status or dependence on respirator?**
   Category ICD-9 V44.0 (Tracheostomy Status)
   Category V46 Respirator Status – HCC 77
   Factor 1.860

3. **Is the patient Protein Calorie Malnourished?**
   Category ICD-9 263
   HCC 21
   Factor .820
   (Cachexia Code 799.4 has the same classification, HCC and Factor)

4. **Is the patient a lower limb amputee?**
   Category ICD-9 V49.70-77
   HCC 177
   Factor .653

5. **Does the patient have Artificial Openings for Feeding or Elimination?**
   Category ICD-9 V44 (with the exception of V44.7)
   HCC 176
   Factor .758

6. **Attention to Artificial Openings for Feeding or Elimination?**
   Category ICD-9 V55.x
   HCC 176
   Factor .758

7. **Does the patient have a major organ transplant?**
   (Heart, Lung, Liver, Bone Marrow, Peripheral Stem Cell, Pancreas, Intestines)
   Category ICD-9 V42.x or xx
   HCC 174
   Factor 1.073

8. **Does the patient have HIV Status?**
   Category ICD-9 V08 Asymptomatic HIV
   HCC 1
   Factor .933

9. **Does the patient have Major Depression?**
   Category ICD-9 296
   HCC 55
   Factor .370

10. **Is the patient Drug Dependent?**
    Category ICD-9 304
    HCC 52
    Factor .250

11. **Is the patient Alcohol Dependent?**
    Category ICD-9 303
    HCC 52
    Factor .250

12. **Has the patient had an MI in the past?**
    Category ICD-9 Code 412
    HCC 83
    Factor .231

13. **Is the patient insulin dependent?**
    Category ICD-9 Code V56.67
    HCC 19
    Factor .181