華人保健計劃 CCHP Health Plan

Clinical Documentation Standards

2020

Requirements

- Documentation must be clear, concise, complete, consistent, and legible
- All notes must contain:
  - Patient Name
  - DOB or other unique identifier
  - Date of Service
- Signature including credentials ***authenticated within 72 hours of visit***.
- Face-to-face encounter with acceptable provider type & setting

Common issues identified for clinical documentation improvement

- Listing diagnoses without **MEAT**
- List of prescriptions (not updated and not linked to the plan)
- Problem list inactive and outdated
- Referrals: not documented
- Diagnostic reports that do not *include physician interpretation*

Documentation for Every Diagnosis must have the M.E.A.T

Monitor Signs and symptoms Disease progression Disease regression	**Evaluate** Effectiveness of medication(s) Response to treatment Test Results ***"improving", "exacerbation***
Address Order diagnostic studies Interpretation Counsel or advice Review record Cause and effect Advanced Directive (P4P)	**Treatment** Prescribe alter medications Initiate or adjust therapies other modalities. Refer to Specialist, Admit.

History of

- Use "history of" *if the patient's* ***medical condition no longer exists and is not receiving any treatment***
- Should not be used for ***chronic conditions receiving current treatment***
- *If the condition exists, and if stable status, the condition is* ***ACTIVE****...document and code the condition (i.e. hypertension and diabetes controlled are still considered active diagnoses)*
- **Use "Z codes"**

EXAMPLE: ***Z86.718 for Personal history of other venous thrombosis or embolism when on Coumadin for at least 6 mo.'s & stable.***

Once a Year...

- Document all chronic conditions and active status conditions
- Review medications: at each visit, and update all at the first of the year visit to reflect current year (i.e., 2020)
- Medical assistants and front desk staff: flag and remind physician of routine physicals and preventative health screenings

Frequently Missed Diagnoses among Medicare patients

- Diabetic Manifestations
- Amputations
- COPD-lifelong
- CHF-lifelong
- Major Depression-documented completely (mild, moderate, severe)
- Secondary neoplasms (path report states "invasive")
- Status codes (i.e. transplant, dialysis)

Commonly Miscoded Diagnoses

- Stroke
- Breast Cancer In Situ
- Acute DVT
- Unknown mass as neoplasm
- Fatty liver
- Invasive neoplasm's
- Diabetic hyperglycemia

Document and Code Annually

	Diagnosis	ICD-10
Amputations	Above knee (AKA)	Z89.61x
	Below knee (BKA)	Z89.51x
	Ankle	Z89.44x
	Foot	Z89.43x
	Toes	Z89.41x (Great toe) or Z89.42x (Others)
Artificial Openin	Colostomy status	Z93.3
	Ileostomy status	Z93.2
gs	Cystostomy status	Z93.5x

exception : closed ostomies

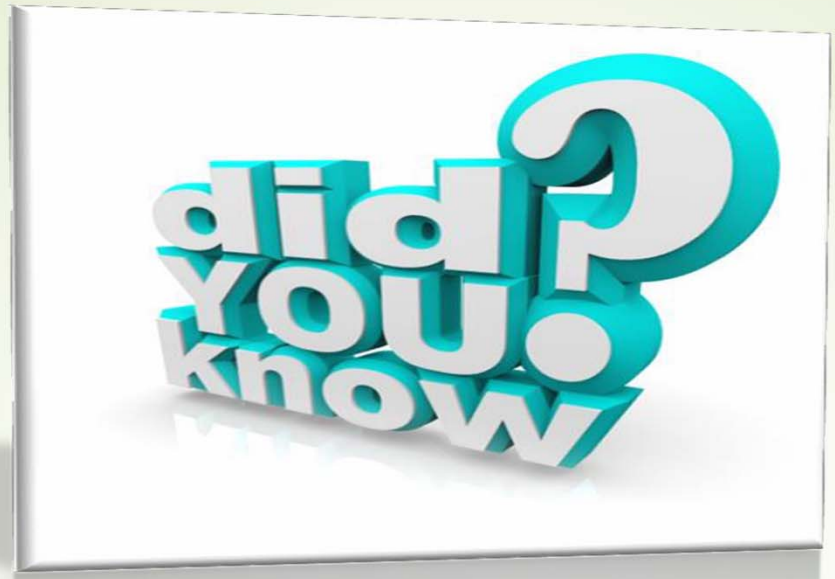
Document and Code Annually

Residual Effects of CVA or Stroke

Diagnosis	ICD-10
Seizures NOS	R56.9
Long term current use of insulin (only if Type 2)	Z79.4
HIV Positive NOS HIV	Z21 B20
Monoplegia of upper limb following CVA left non-dom side	I69.334
Hemiplegia following CVA affecting RT dom. side	I69.351
Quadriplegia NOS	G82.50
Paraplegia NOS	G82.20

Document and Code Annually

	Diagnosis	ICD-10
Transplants Status	Bone Marrow	**Z94.81**
	Stem Cell	**Z94.84**
	Liver	**Z94.4**
	Pancreas	**Z94.83**
	Lung	**Z94.2**
	Heart	**Z94.1**
	Kidney	Z94.0
	Renal Dialysis Status	**Z99.2**



Greater than 90% of seniors with diabetes have a manifestation or complication of diabetes...

DM Manifestations

Document:

- *Manifestations*
- *Co-morbidities*
- *Complications*
- *Meds which control both conditions*

DM with Manifestation	ICD-10
With CKD	**E11.22 (Type II)** **Use an additional code for CKD stage**
****With ophthalmic manifestations**	**E11.3xx (Type II)**
With neurological manifestations	**E11.4x (Type II)**
With peripheral circulatory manifestations (document type of condition, PAD or other)	**E11.5x (Type II)** **Use an additional code for foot ulcers**

Chronic Cardiovascular Conditions

- Document and code ongoing chronic conditions such as "**atrial fibrillation**" or other specific "**arrhythmias**" symptomatic or asymptomatic
- Document treatment: pharmacological/interventional cardiology
- Angina resolved with PTCA or CABG and no further medication – codes to history of angina.
- Sinus Sick Syndrome is considered "cured" with a current pacemaker-codes to history of sinus sick syndrome.

Specific Arrhythmias

Diagnosis	ICD-10
Atrial fibrillation	I48.91
Atrial flutter	I48.92
Sick sinus syndrome	I49.5
Atrioventricular block, complete	I44.2
Paroxysmal supraventricular tachycardia (PSVT)	I47.1

Congestive Heart Failure (CHF)

CHF is chronic after definitive diagnosis and should be documented, coded, and treated as such.
Echocardiograms to evaluate and document diastolic heart failure.

Document the **type** of CHF:

- Systolic
- Diastolic
- Combined diastolic and systolic
- Unspecified

Acuity:

- Acute
- Chronic
- Acute on chronic
- Unknown or unspecified

Malnutrition

Indicators

- Anorexia
- Failure to thrive
- Abnormal weight loss
- Loss of appetite
- Muscle wasting
- Underweight
- Low BMI
- Rx TPN

Consider the following:

- Malnutrition, mild degree **E44.1** *(BMI 16-17.9 Albumin <3.5)*
- Malnutrition, moderate degree **E44.0** *(BMI <16.0 Albumin <3.5)*
- Cachexia **R64** *(Advancing malnutrition with tissue wasting*
- *Document and code underlying condition (e.g. Neoplasm)*

Obesity

- To code “morbid obesity” with a BMI 40 and above document the clinical rationale.

- Document co-morbid conditions:
  - Diabetes
  - Obstructive sleep apnea (or Pickwickian syndrome)
  - CAD
  - Hypertension – not well controlled
  - Depression

Obesity

Diagnosis	ICD-10
Overweight	E66.3
Obesity	E66.9
Morbid (severe) Obesity	E66.01
BMI 40.0 - 44.9 BMI 45.0 – 49.9 BMI 50 – 59.9 BMI 60.0 – 69.9 BMI 70 or greater	Z68.41 Z68.42 Z68.43 Z68.44 Z68.45
Obesity hypoventilation syndrome hypoventilation, somnolence and erythrocytosis	E66.2

Major Depression

Document characteristics

- **Episode**: Single or recurrent episode
- **Severity**: Mild, moderate, or severe
- **In partial or in full remission** (when applicable)

If no documentation of specific descriptors in addition to "Major", defaults to F32.9, **which is not specific and has no HCC weight**

Document chronic lifetime conditions annually such as Schizophrenia and Bipolar disorder

Dependence

Diagnosis	ICD-10
Alcohol dependence/alcoholism (without remission)	F10.20
Drug dependence- opioid, oxycontin dependence	F11.20
Sedative, Hypnotic, or Anxiolytic Dependence	F13.20

Do **NOT** code "abuse" when a patient has chronic dependence/use

Pulmonary

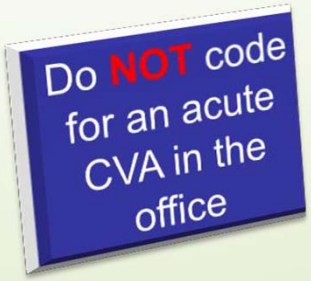
Diagnosis	ICD-10
Simple chronic bronchitis/smokers cough (chronic cough or mucus production for 2-3 months out of the year in 2 successive years)	J41.0
Emphysema (damage to the alveoli frequently diagnosed by smoking hx, wheezing, CXR or CT findings and obstructive or decreased perfusion capacity by PFT)	J43.x
COPD, Chronic airway obstruction + smoking hx, wheezing, CXR or PFT (FEV1/FVC<70%	J44.x
Asbestosis	J61
Idiopathic pulmonary fibrosis	J84.112

Neurology

- Codes for **acute CVA** are primarily for ER and inpatient codes.
- After the initial event use *history of CVA* or *late effects of CVA.*
- Document any residual effects of a stroke.
- If no residual effects= H/O CVA Z86.73 (not HCC)

Document and code "late effects of CVA" or sequela.

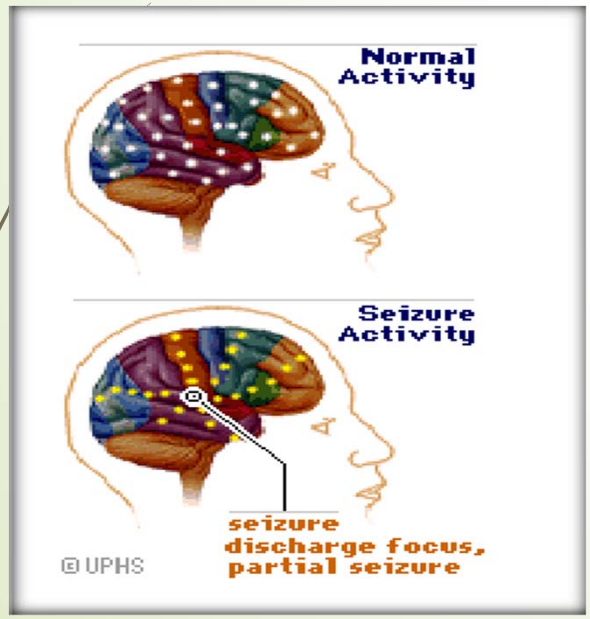
Diagnosis (Late effects or Sequela of CVA)	ICD-10
Hemiplegia	I69.95x
Monoplegia	I69.93x (upper limb) I69.94x (lower limb)
Other paralytic syndrome	I69.96x
Speech and language deficit	I69.920 (Aphasia) I69.921 (Dysphasia) I69.922 (Dysarthria) I69.923 (Fluency disorder) I69.928 (other)
Other sequela or late effects of CVA	I69.990 (Apraxia) I69.991 (Dysphagia) I69.992 (Facial weakness) I69.993 (Ataxia) I69.998 (other)

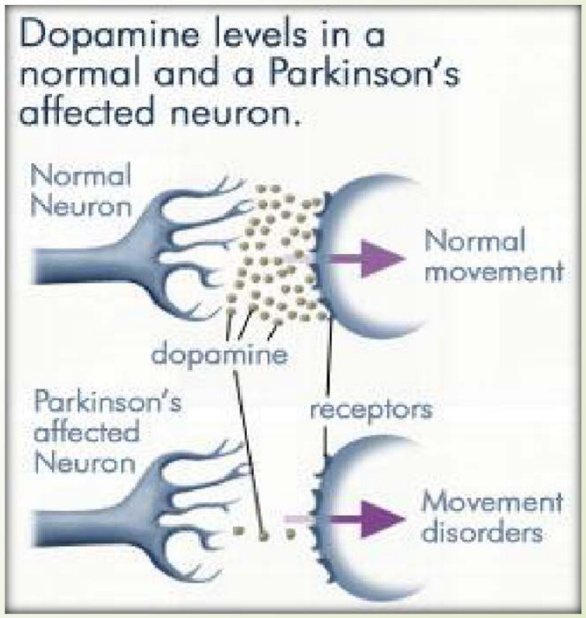


Neurology

Frequently missed :

Seizure Disorder/Epilepsy– G40.909
Parkinson's disease – G20





Oncology

Malignancies are ***only coded until the patient has completed definitive treatment such as surgery, chemotherapy and/or radiation therapy to eradicate the malignancy.***

If the patient has refused or delayed definitive treatment for a malignancy and has instead opted for "watchful waiting", it is appropriate to code for active cancer; surveillance is occurring for disease progression, not the recurrence of it.

Breast and Prostate CA patients on adjuvant therapy such as tamoxifen or Lupron, are coded as if they have active disease.

Patients who have completed treatment can only be coded with a "*personal history of cancer*" diagnosis code, even if they are undergoing surveillance for re-occurrence of the malignancy.

Gastroenterology Codes

Diagnosis	ICD-10
Chronic hepatitis, unspecified	K73.9
Autoimmune hepatitis (Lupoid hepatitis NEC)	K75.4
Chronic Viral Hepatitis B (with delta)	B18.0
Chronic Viral Hepatitis B (without delta)	B18.1
Chronic Hepatitis C (with or w/o) Hepatic coma	B18.2
Other chronic viral hepatitis	B18.8
Chronic viral hepatitis, unspecified	B18.9

Hepatitis

- Accurate coding of hepatitis depends on clear **documentation of the cause**
- Code selection is based on:
  - Serotype (viral type)
  - If Hepatitis B with or w/o type D co-infection
  - Acute or chronic phase (only **chronic** forms of hepatitis risk adjust)
  - With or w/o hepatic coma
- If documentation states "acute and chronic" hepatitis, a code for each condition should be assigned.
- Document if patient is a carrier or a suspected carrier of the hepatitis virus

Rheumatoid Arthritis

- Criteria:
  - Morning stiffness
  - Arthritis of 3 or more joint areas with soft tissue swelling or joint effusion
  - Arthritis of hand joints
  - Symmetric arthritis
  - Rheumatoid nodules
  - Serum rheumatoid factor
  - Radiographic changes that must include erosions decalcification localized adjacent to the involved joints

Four of the seven criteria are required to classify a patient with RA