OPTUM™

A Comprehensive Diagnostic Patient Profile

The Importance of Good Documentation and Coding

Good documentation and coding clearly depict the level of disease severity, comorbidities, underlying disease and other factors that contribute to the level of complexity for the patient encounter.

Per the ICD-9-CM Official Guidelines for Coding and Reporting:[1]

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

Payment from Centers for Medicare & Medicaid Services (CMS) is based on the overall health status of the Medicare Advantage member. Diagnosis codes are some of the criteria used for determining severity of illness, risk and resource utilization. Diagnostic coding influences the "level of risk" in determining CPT® code assignment.

Moderate risk is equivalent to either:

a) One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment
b) Two or more chronic stable illnesses

High risk relates to either:

a) One or more chronic illnesses with severe exacerbation, progression or side effects of treatment
b) Acute or chronic illnesses or injuries that pose a threat to life or body function

Status codes can also indicate and contribute to the complexity level of the encounter. Consider these V codes:

Renal Dialysis Status or Noncompliance	**V45.11 or V45.12**
Tracheostomy Status	**V44.0**
Respirator Dependence	**V46.11**
Lower Limb Amputee	**V49.7X**
Artificial Openings for Feeding or Elimination	**V44.X** and **V44.5X**
Organ Transplant Status	**V42.X to V42.8X**
Asymptomatic HIV Status	**V08**

The presence of one or more of these conditions should be taken into account by the provider in the decision making process and could affect patient care, treatment and management. Other diagnosis codes that are not often reported, although the patient is being treated for the conditions, are:

Protein-Calorie Malnutrition	**263.X**
Major Depressive Disorder	**296.2X** and **296.3X**
Alcohol Dependence & Drug Dependence	**303.XX** and **304.XX**
History of Heart Attack	**412**

Good documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal.

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[1]"ICD-9-CM - International Classification of Diseases, Ninth Revision, Clinical Modification." Centers for Disease Control and Prevention. Web. 27 Jan. 2012. <http://www.cdc.gov/nchs/icd/icd9cm.htm>

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