Best practices for documentation and coding

For HealthSpring® providers

HealthSpring is committed to accurate and complete coding that establishes comprehensive records our members' health status. Adopting these best practices and following coding guidelines will help ensure correct reporting of conditions.

Documentation essentials

Follow these tips to enable a successful translation of written notes into International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes that support the submitted diagnoses:

- Document when a condition affects the care, treatment, management of the patient and when it affects medical decision-making.
- State the condition completely in the assessment; an ICD-10-CM code alone is insufficient.
- Ensure the diagnostic statement includes applicable specificity for the condition and code assignment.
- Code to the highest degree of specificity based on documentation in the record and avoid unspecified and generic codes when possible.
- Do not document "history" in connection with an active condition.
- Document conditions as many times as the condition is treated and at least once per calendar year.
- Ensure all active conditions have a treatment plan.
- Never code directly from problem or history lists; code only conditions that have been assessed and treated.
- Ensure documentation is clear, concise, consistent, complete and legible.
- Document a link between a primary condition and an established complication or manifestation.

History versus current

When documented in the medical record, the term "history" will always translate into a code for a resolved condition.

Documented as	Reported
History of congestive heart failure	Indicates that congestive heart failure has resolved. Has it been resolved?
History of leg amputation	Report a status code as absence of leg.
Stroke five years ago	Report personal history of stroke, or if there are late effects, report the sequela.
History of breast cancer	Reported as a personal history of malignant neoplasm of the breast when disease has been eradicated and there is no further treatment.
History of chronic kidney disease	Indicates that chronic kidney disease has resolved. Has it been resolved?
Myocardial infarction two months ago	Report a history of acute myocardial infarction or aftercare when infarction occurred more than 28 days ago.

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Historical conditions are often documented as current and reported as an active condition.

Documented as current	When to report
Stroke	Document and report only during admission for acute phase. Subsequent encounters must report a history of the infarction or hemorrhagic event or the resulting sequela.
Myocardial infarction	An acute myocardial infarction and all related services performed within the following 28 days are reported with a current myocardial infarction code (ICD-10 code category I21). A historical code or aftercare must be reported after 28 days.
Cancer	Document only for current cancer. Report history of cancer when it is excised or eradicated, **and** treatment is complete.

Past medical history and problem lists

- Differentiate between resolved conditions and those that are current and actively being treated. For example, previous surgeries or infectious processes, such as pneumonia, which have been treated and are no longer active.
- Current problem lists should be updated periodically to reclassify any resolved conditions for the past medical history.
- Review the problem list to confirm that all active conditions are being treated and accurately documented each year.

Specificity and generic codes

- Nonspecific codes may not accurately reflect a patient's condition; a common example is congestive heart failure. Many providers use the generic code I50.9 for heart failure; however, specific codes exist for different types of heart failure. The signs and symptoms of various forms can be different. Nonspecific codes may not describe the patient and how the disease is affecting their health.
- Code to the highest degree of specificity based on documentation in the record. If the electronic medical record or coding tools provide multiple specific options for a condition, report to the level of specificity available.

Linking conditions

Document the connection if a cause-and-effect relationship exists between diseases. For example, peripheral neuropathy can manifest because of diabetes. Diabetes, hypertension, renal failure, congestive heart failure and coronary artery disease are additional clinical examples that demonstrate this cause-and-effect relationship. How you document the "link" is important. Words such as "in," "due to" or "with" identify a link between a primary condition and an established comorbidity.

Documentation MUST fully support the reported condition

- Successful reporting requires a joint effort among providers, coders and HealthSpring.
- Providers document a condition in writing, but the Centers for Medicare & Medicaid Services requires diagnosis data be submitted using ICD-10-CM codes. A coder uses the official coding guidelines to translate the written language documentation into the corresponding code.
- Diagnosis codes may be rejected by CMS if the documentation and code assignment do not adhere to the guidelines.
- Open communication with coders and a good understanding of the electronic medical record's code assignment process will help ensure that the intended diagnoses are reported and accepted.

The subjective, objective, assessment and plan (SOAP) note format is a common tool used as a framework for documenting information in a medical record and is recommended to ensure the supporting documentation is captured in its entirety.

Electronic medical record systems may not use the same SOAP categories, but they are generally organized in a similar format. There are two more acronyms that remind us to capture all relevant components performed to fully support a diagnosis: MEAT (monitor, evaluate, assess, treat) and TAMPER (treat, assess, monitor, plan, evaluate, transfer).

Providers must confirm the accuracy of reported diagnoses and ensure that their practices comply with the ICD-10-CM Official Guidelines for Coding and Reporting and applicable legal requirements. Accurate and complete risk adjustment documentation, coding and submission activities allow HealthSpring to provide quality care and resources to your patients. If you believe any codes were previously submitted in error, contact your Provider Education specialist, or email ProviderEducation@HealthSpring.com.

This communication is for informational purposes only and is not intended to influence, direct or interfere with the independent clinical judgment of health care providers. All medical decisions, including diagnoses, assessments and treatment plans, remain at the sole discretion of the treating provider, based on their professional expertise and patient-specific considerations.