Blue Cross Blue Shield of Michigan
and
Blue Care Network

Documentation and Coding Tips for Professional Offices

None of the information included herein is intended to be legal advice and as such it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

It all begins with documentation

What's the reason for the office visit?

The office visit note should consistently demonstrate the nature of the presenting problem(s). The *assessment*, *plan* and *diagnoses* need to be complete and consistent with the visit reason in order to support medical necessity.

Follow the **M.E.A.T.** concept for documenting diagnoses.

- **M**anaged
- **E**valuated
- **A**ssessed
- **T**reated

Each reported diagnoses must have a plan of treatment that includes at least one of the criteria from the M.E.A.T. concept.

Documentation must support the ICD-9-CM diagnoses that are reported and there must be a treatment plan for each diagnosis.

Diagnosis	M.E.A.T. Concept
Atrial flutter: ICD-9-CM code 427.32	How was this condition managed during the visit?
History of breast cancer V10.3	How was this condition evaluated or assessed during the visit?
Malignant neoplasm of female breast unspecified, 174.9	What is the treatment of the cancer? Treatment may include radiation or prescription while in remission, such as tamoxifen.

It all begins with documentation

Remember that a diagnosis can only be coded when it's EXPLICITLY described in the progress note. In the *outpatient setting*, use caution with terms like "rule out," "consistent with" or "probable" as these terms can't be coded as the patient actually having that condition or disease.

Chronic conditions that affect medical management must be documented annually, whether they are *controlled by medication*, *stable* or *compensated*.

Manifestations are an extension of the original condition. Example: Neuropathy **due to** diabetes.

'History of' is only appropriate in the assessment *if the patient has been cured* or no longer has the disease.

Office visit note tips:

- The assessment needs to reflect diagnoses relevant to the office visit. That includes conditions or other reason(s) for the visit or procedure to support medical necessity.
- The status of the condition or disease needs to be stated as new, stable, controlled, managed, etc.
- Clearly state the treatment plan.

Criteria for the medical record

The medical record must include:

- A legible handwritten or electronic signature that includes the provider's full name and credentials after the name. **Signature stamps are not acceptable**.
- Acceptable *electronic authentication examples* include:
  - Approved by
  - Authorized by
  - Completed by
  - Signed by
- Patient name, ID and visit date must be on each page.
- The progress note must be legible to persons other than the author.
- All the patient's chronic diagnoses should be documented annually, including an update of the status of each condition.
- The medical record should include a follow up plan including tests ordered, referrals made, patient instructions and when the next patient visit should be scheduled.
- The medical record should be organized in a logical fashion and clearly demonstrate the visit was "*face to face.*"

For your patients with vascular diseases

For a comprehensive patient representation:

- Document assessment, evaluation and treatment of conditions such as peripheral vascular disease and deep vein thrombosis.
- Aortic atherosclerosis and peripheral atherosclerosis are chronic conditions that should be assessed, documented and coded each year.

Common vascular conditions	ICD-9-CM Codes
Aortic atherosclerosis	440.0
PVD (peripheral artery disease, intermittent claudication, etc.)	443.9
Acute DVT (initial episode of care)	*453.4x
Chronic DVT	*453.5x
Acute pulmonary embolus (initial episode of care)	415.19
Chronic pulmonary embolus	416.2

***Please review the ICD-9-CM coding manual for the fourth and fifth digit subcategories for greater specificity in code selection.**

For your patients with heart disease

Heart failure - ICD-9-CM code *428.xx

- Key symptoms may include shortness of breath (SOB), chest pain (CP), edema diagnosed by clinical findings, X-ray or echocardiogram.
- Be specific. Use codes for systolic, diastolic, and congestive heart failure.
- Codes also exist for acute on chronic heart failure

Myocardial infarction (MI) and angina pectoris

- Document these conditions as opposed to the less specific coronary artery disease (CAD) or atherosclerotic heart disease (ASHD), if appropriate
- For a MI > 8 weeks, you should document and code 412

Document and code annually for ongoing *atrial fibrillation*, *atrial flutter* or other *arrhythmias* that require medication management.

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For your patients with respiratory disease

Document and code chronic pulmonary diseases annually.

These conditions include: chronic obstructive pulmonary disease, chronic bronchitis and emphysema.

ICD-9-CM codes to consider

*491.2x Obstructive chronic bronchitis	*492.x Emphysema	496 COPD NOS	V44.0 Tracheostomy status

- *Perform yearly spirometry test for all at risk patients.*
- *Review all patients for frequent acute bronchitis and multi-inhaler prescriptions for possible chronic bronchitis and COPD.*

For bacterial pneumonia, be sure to document and code for the specific organism.

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For your patients with cancer

- This includes benign tumors or tumors of uncertain behavior. Examples include neoplasm of brain, cranial nerve (acoustic neuroma), spinal cord, pituitary, and pineal gland.
- An active cancer diagnosis should continue until the patient has completed definitive treatment that includes surgery, chemotherapy or radiation therapy that is aimed at eradicating the cancer.
- Only patients who have completed therapy and whose cancer has been *eradicated* can be given a "personal history of cancer" diagnosis (V10.00-V10.91), even if they are undergoing surveillance for re-occurrence of the cancer. *(Exceptions are the different forms of leukemia.)*
- Patients who haven't received definitive treatment for their malignancy should continue to have an active cancer diagnosis.
- Patients on adjuvant therapy (tamoxifen, Lupron, Casodex® and 5-FU) are coded as if they have active disease, i.e., breast cancer *(174.x) or prostate cancer (185).

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For your patients with rheumatoid arthritis & inflammatory connective tissue disease

- Rheumatoid arthritis (RA) is considered a *chronic condition* and may be captured from a patient's medical history or a problem list.
- Please note: Joint pain or a diagnosis of arthritis is not considered RA.
- Pathological fractures need to be documented since they are not assumed.
- *Sacroiliitis* is defined as pain due to joint inflammation at the juncture of the sacrum and hip.
- *Osteomyelitis* is a condition that requires documentation describing the area or site.

Clinical criteria to code RA:

Chronic inflammatory disorder for more than six weeks, diagnosed clinically with four out of the following:

- Affecting three or more joints
- *Symmetrical* joint pain
- Rheumatoid nodules
- Erosion on X-ray
- Morning stiffness

Examples of unspecified vs. detailed diagnoses

Arthritis	Rheumatoid arthritis
Fracture	Pathological fracture
Hip and back pain	Sacroiliitis
Joint disorder	Osteoarthritis

For your patients with neurological diseases

Polyneuropathy is a chronic (unless stated as acute) neurological disorder affecting many nerves throughout the body.

Document and code for chronic neurological conditions at least annually.

The following are some common conditions to consider:

Conditions to consider	ICD-9-CM Code
Parkinson's	332.0 or 332.1 (secondary)
Cerebral palsy	343.9
Multiple sclerosis	340
Quadriplegia/Paraplegia	*344.xx & 344.1
Epilepsy and recurrent seizures	*345.xx

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*Keep in mind for your patients with polyneuropathy due to diabetes mellitus, code the diabetes condition first: code *250.6x; then code the polyneuropathy; code 357.2.*

For your patients with diabetes and neuropathy

Document the ***cause and effect relationship*** if your patient's neuropathy is secondary to diabetes to capture and code as a diabetic condition.

Neurological conditions may affect a patient's memory and ability to perform daily activities. It is important to document treatment of these conditions once a year.

You can establish a "link" between diabetes and neuropathy by documenting the following:

- Diabetes **with** neuropathy
- Diabet**ic** polyneuropathy
- Neuropathy **caused by** diabetes
- Polyneuropathy **associated with** diabetes

For example, when documentation supports a "link" between uncontrolled diabetes type II and neuropathy on *insulin*, the code assignment would be:

- **250.62** - Diabetes mellitus with neurological manifestations, type II or unspecified type, uncontrolled
- **357.2** - Polyneuropathy
- **V58.67** - Long-term (current) use of insulin

By documenting the ***cause and effect relationship***, you can capture and code a more complete picture of your patient's overall health.

For your patients with diabetes and peripheral vascular disease

Document the ***cause and effect relationship*** if your patient's peripheral vascular disease is secondary to diabetes to capture and code as a diabetic condition.

You can establish a "link" between diabetes and peripheral vascular disease by documenting the following:

- Diabetes **with** peripheral vascular disease
- Diabet**ic** peripheral vascular disease
- Gangrene **caused by** diabetes
- Peripheral vascular disease **secondary** to diabetes

For example, when documentation supports a link between diabetes type I and peripheral vascular disease on *insulin*, the code assignment would be:

- **250.71** - Diabetes mellitus with peripheral circulatory disorders, type I or unspecified type, not stated as controlled
- **443.81** - Peripheral angiopathy

By documenting the ***cause and effect relationship***, you can capture and code a more complete picture of your patient's overall health.

For your patients with diabetes and ophthalmic complications

Document the ***cause and effect relationship*** if your patient's eye disease is due to diabetes to document and code as a diabetic condition.

You can establish a "link" between diabetes and eye condition by documenting the following:

- Diabetes **with** nonproliferative retinopathy
- Diabet**ic** macular edema
- Proliferative retinopathy **due to** diabetes
- Cataract **caused by** diabetes

For example, when documentation supports a "link" between diabetes type II and diabetic retinopathy on *insulin*, the code assignment would be:

- **250.50** - Diabetes mellitus with ophthalmic manifestations, type ll or unspecified type, not stated as controlled
- **362.01** - Diabetic retinopathy NOS
- **V58.67** - Long-term (current) use of insulin

By documenting the ***cause and effect relationship***, you can capture and code a more complete picture of your patient's overall health.

For your patients with diabetes and kidney disease

Document the ***cause and effect relationship*** if your patient's chronic kidney disease is due to diabetes to capture and code as a diabetic condition.

You can establish a "link" between diabetes and kidney condition by documenting the following:

- Diabetes **with** chronic kidney disease, Stage I
- Diabet**ic** chronic kidney disease, Stage III
- Chronic kidney disease, Stage I **due to** diabetes
- Chronic kidney disease, Stage II **secondary to** diabetes

For example, when documentation supports a "link" between diabetes type II and chronic kidney disease, Stage I, the code assignment would be:

- **250.40** - Diabetes mellitus with renal manifestations, type II or unspecified type, not stated as controlled
- **585.1** - Chronic kidney disease, Stage I

By documenting the ***cause and effect relationship***, you can capture and code a more complete picture of your patient's overall health.

For your patients with chronic kidney disease

Terms like "chronic renal disease" and "chronic renal insufficiency" are considered outdated because they are nonspecific and can mean any degree of kidney failure, including end stage renal disease (ESRD).

As endorsed by the National Kidney Foundation, the term "chronic kidney disease" (CKD) should be used and classified into one of the five stages.

Stage	ICD-9-CM
1	585.1 - Chronic kidney disease, Stage I
2	585.2 - Chronic kidney disease, Stage II (mild)
3	585.3 - Chronic kidney disease Stage III (moderate)
4	585.4 - Chronic kidney disease, Stage IV (severe)
5	585.5 - Chronic kidney disease, Stage V 585.6 - ESRD V45.11- Renal dialysis status

CKD is permanent kidney damage or decreased level of kidney function that continues for three months or more.

When left untreated, CKD can lead to complete kidney failure. Leading causes of CKD are **high blood pressure** and **diabetes mellitus**.

For your post-cerebrovascular accident patients

- ICD-9-CM diagnosis code *434.9x is used for the initial episode for an acute cerebrovascular accident. Acute CVA usually occurs in the hospital setting.
- **History** of a CVA with no residual effects can be coded using V12.54
- ***Late effects:*** *ICD-9 438 series* "Late effects of cerebrovascular disease." This category is used to indicate conditions in 430-437 as the cause of late effects.
  - Late effects may be present from the onset or may arise any time after the acute phase.
  - There is no time limit on coding late effects of a CVA.
  - Late effects may be documented as long as the condition persists.
  - Weakness vs. hemiparesis. *Please be specific with documentation.*

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For your patients experiencing cardio-respiratory failure and shock

Cardio-respiratory failure is a state of intense disturbance of blood flow/circulation and metabolic disturbance characterized by failure to maintain sufficient perfusion of vital organs.

- When your documentation indicates **chronic** respiratory failure, ICD-9-CM code 518.83 is used.
- When documentation indicates hypoxia, anoxia, anoxemia, pathological anoxia or hypoxemia, ICD-9-CM code 799.02 is used.

Chronic conditions that impact medical management must be documented at least annually, whether they are *controlled by medication*, *stable* or *compensated*.

For your patients experiencing chronic ulcers of the skin

- **Chronic ulcer of the skin** is not to be confused with a **wound**, **sore** or **skin breakdown**.
- It's unnecessary to note the stage when documenting **chronic skin ulcers** (unlike decubitus ulcers).
- Risk factors for pressure or **decubitus ulcers** include:
  - Bedridden patients
  - Chronic conditions like diabetes mellitus or vascular disease
  - Immobility due to brain or spinal injury
  - Wheelchair dependent
- Pressure or decubitus ulcer stages:
  - Unspecified stage
  - Stage I
  - Stage II
  - Stage III
  - Stage IV
  - Unstageable

Decubitus ulcers require staging in accordance to the progression of the ulcer. Also, documentation should note the location of the ulcer, and whether it's heal**ed** or heal**ing**.

For your patients experiencing depressive, bipolar and paranoid disorders

- Not to be confused with situational depression (311) or depressed mood due to bereavement (309.0)
- *Major depressive*, *bipolar* and *paranoid disorders* require very specific documentation not common to most primary care providers
- Symptoms >Two+ weeks which cause impairment
- At least one of the following:
  - Depressed mood most of the day, nearly every day
  - Diminished interest in activities
- At least four of the following:
  - Weight/appetite loss or gain (5 percent in a month)
  - Insomnia or hypersomnia
  - Agitation or retardation observed by others
  - Feelings of worthlessness or guilt
  - Diminished ability to think or concentrate
  - Recurrent thoughts of death, suicide ideation or attempt

For your patients experiencing complications with implants or medical devices

This includes conditions that are a result of medical care or trauma.

Examples:

- Post-**traumatic** wound infection
- Mechanical failures of pacemakers or implantable cardiac defibrillators, such as broken lead wires, defective housing or device recall.
- Mechanical complications of orthopedic device or implant
- Infection or inflammation of internal device or implant
- To accurately capture an infection or inflammatory reaction as a result of an indwelling *urinary* catheter, the catheter must have been in place before the infection occurred and the documentation must demonstrate that the catheter caused the infection.
- Complication codes for medical implants or other medical devices can be found in the *996.xx series in the coding manual.

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For patients at risk for malnutrition

The elderly population is more inclined to develop malnutrition and associated health conditions. Some associated conditions include Crohn's disease, cancer, malabsorption syndrome, and anemia. Diagnosis of malnutrition should be detailed.

Protein-calorie malnutrition may accompany:

- Normal aging
- Cancer
- Drug or alcohol abuse and/or dependence
- Liver disease
- Anemia

Conditions associated with malnutrition	
Cachexia	799.4
Malnutrition – Mild or Moderate	*263.x
Severe protein calorie malnutrition	262

Treatments may include:

- Dietary consults
- Supplementary feedings via nasogastric tube
- Total parenteral nutrition

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"I code completely and accurately."