Things to Remember When Documenting and Coding

Here are some things to consider when choosing and documenting ICD-10-CM codes.

Specificity

Provide complete and detailed documentation. This helps ensure your patient receives the correct diagnosis. Where appropriate, your documentation should include:

- Chronic vs. acute.
- Severity.
- Location/laterality.
- Cause.
- Duration.

Example: For a patient with type 2 diabetes mellitus with chronic kidney disease stage 3a, report E11.22 and N18.31 instead of type 2 diabetes mellitus without complication E11.9.

Causal Relationship

Provide details of your patient's condition using words that show a relationship between their conditions and manifestation. Use words like "with," "due to" and "associated with."

Example: Peripheral neuropathy due to type 2 diabetes mellitus (E11.42).

Sequelae (Late Effects)

Use of sequelae codes require the documentation of any previous disease, chronic condition or injury that's resulted in a secondary diagnosis. Using sequelae codes provides a more accurate description of your patient's health history and current health status.

Example: Hemiplegia affecting right dominant side due to stroke I69.351 that occurred three months ago for a patient receiving physical therapy services.

Commonly Missed Codes

Missed codes can affect the course of treatment and patient outcomes. Make sure to document and report the following commonly missed codes, when applicable, during a face-to-face encounter with your patient at least once every calendar year:

Description	ICD-10
Alcohol Dependence, in Remission	F10.21
Amputation Status	Z89.011-Z89.9
AAA Without Rupture	I71.4X
Asymptomatic HIV Status	Z21
Dialysis Status	Z99.2
Drug Dependence	F19.20-F19.29
Morbid Obesity	E66.01
Ostomies	Z93.0-Z93.9

Tip:
"X" is a placeholder character and is not reflective of a complete code. Please refer to the official 2023 ICD-10-CM code set for proper code selection.

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Active vs. History of Cancer

Active cancer:

- Cancer is present and/or your patient is currently receiving treatment. This includes neoadjuvant and adjuvant therapy.
- Your patient isn't receiving treatment, but cancer is present (e.g. indolent disease, patient refuses treatment).

History of cancer:

- There's no current evidence of cancer, and all active and adjuvant treatments have stopped.
- Your patient is receiving a selective estrogen receptor modulatory (SERM) drug as prophylactic treatment when cancer is not present.

M.E.A.T.

When documenting your patient's medical condition, use the acronym M.E.A.T.

- **Monitor** – Signs, symptoms, disease progression.
- **Evaluate** – Medications, test results.
- **Assess/Address** – Counseling, review of records.
- **Treat** – Medications, therapy.

Conditions on the problem list, without further documentation, do not accurately represent a patient's health status and do not meet the requirements for supporting documentation.

Best Practice Documentation for Persisting Chronic Conditions and HCCs

Sections to Document Diagnoses and Support	Maintain and Update (So You Can Pull into Visit Notes)
History of Present Illness	Active Problem List
Assessment and Plan	Past Medical History List
Review of Systems	
Physical Exam	

Tip:
Review and update lists for EMR and documentation accuracy.

Passive vs. Active Voice

Passive Voice: No Ownership, Past Tense	Active Voice: Ownership, Present Tense
"History of"	"Patient has"

Tips:

- Document in the "active voice" for coding support.
- Providers must document the link between conditions and medications; coders cannot assume the linkage.
- Providers must document that a condition affected the care and management of the patient for each encounter it is reported.
- Coding may not come from the past medical history or the active problem list.

Optum 360 ICD-10-CM Expert for Physicians

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