

Why is accurate coding important?

Accurate coding benefits you, your patients and the insurer by providing financial health to your practice. Accurate medical records and diagnosis codes captured on claims **helps reduce the administrative burden of adjusting claims**. Accurate coding also offers you opportunities to improve care by identifying high risk patients. Once you've identified the high risk patients, it could be beneficial to engage patients in disease and case management programs, and care prevention initiatives.

Records must:

- Be complete and legible to all who read them, not just the provider.
- Include the patient's name and record number (or an identifier such as date of birth) on every page of the record.
- Include provider signature, credentials, and date of service, whether hand written or electronically signed.

Tips for complete and accurate coding and documentation

It is critical to fully document and code each encounter. The claim should include the ICD code of every diagnosis that was addressed during the visit and those that influenced the member's care.

- Document only what is known at the time of the visit/encounter.

- Do not code for a condition if it is not confirmed or is uncertain (suspected, probable, rule out, etc.) for non-inpatient charts.
- Code only the known signs and symptoms present at the time the patient is seen.
- Code for a condition only when it is confirmed by testing or additional results, and update the medical record accordingly.
- Support all condition diagnosis codes for date of service and be able to stand alone for a particular date of service (e.g., no references to previous dates of service without a complete description of the information from that earlier date of service).
- Code to the highest level of specificity possible. For example, if there are neurological or circulatory manifestations present as a result of diabetes, specify exactly what the manifestations are (e.g., reduced monofilament sensation or abnormal reduced pulses) and use the terms "caused by," "secondary to," or "due to" the diabetes. Terms like "diabetic neuropathy" or "diabetic peripheral vascular disease (PVD)" also may be used to establish a causal relationship.



Understanding risk adjustment and HCCs

Accurate coding benefits you and your patients.

Risk adjustment is a component of the Affordable Care Act (ACA) intended to reinforce market rules prohibiting risk selection by insurers. The Department of Health & Human Services (HHS) is responsible for operating risk adjustment models.

The Center for Medicare and Medicaid Services (CMS)/HHS use **hierarchical conditional categories (HCCs)** to identify individuals with serious or chronic illness. A risk factor score is assigned to the person based on a combination of the individual's health conditions and demographic details.



Physician data is critical for accurate risk adjustment, as it relies on accurate diagnosis coding on claims and complete medical record documentation. CMS/HHS employ a multi-step data validation audit process, performed at random, to ensure diagnoses are substantiated by medical records.

CMS/HHS conducts **risk adjustment data validation (RADV)** by reviewing medical records used to substantiate coded claims.

If you have questions, please contact your Provider Relations representative at 785-291-4135.