Complete, Accurate and Specific Documentation and Coding

Desk Reference

HealthCare Partners, IPA
HealthCare Partners, MSO

Introduction:

Medicare Advantage is a government funded healthcare benefit overseen by the Centers for Medicare & Medicaid Services (CMS). CMS utilizes many processes to support the provision of healthcare including the CMS-Hierarchical Condition Category (HCC) based risk adjustment model. Risk adjustment is a system that considers the overall health status of individuals to appropriately allocate the resources necessary to support the expected healthcare needs. It is our objective at HealthCare Partners, IPA to empower our physician partners with the support, tools, and education needed for them to succeed in documenting the up-to-date, accurate, specific, complete health conditions of their patients.

Disclaimer:

This reference is intended to provide the most frequent risk adjustable ICD-10-CM diagnosis codes for conditions used in the inpatient and outpatient settings. It is not a complete list of ICD-10-CM codes, and is for informational purposes only. It does not define a standard of care and should not substitute for an informed medical evaluation, or diagnosis and treatment performed by a licensed healthcare provider. HealthCare Partners, IPA does not warrant nor represent that the information contained herein is accurate or free from defects, and recommends that providers follow all up-to-date guidelines published by CMS.

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General Coding			
fsgf	**Post-Acute Care for Stroke**	● Documenting acute stroke **ends** at hospital discharge. ● **History** of CVA should be documented **only** if there are **no residual deficits**. ● **Sequelae** of CVA should be documented if there **are any residual deficits**, and can be documented **annually** until those deficits have completely resolved.	● Refer to the Provider HCC Risk Adjustment Diagnosis Correct Coding Guide
General Coding	**Amputations and Ostomies**	● A**t the beginning of the year, CMS resets the condition list for patients back to zero conditions.** ● Even **amputations and ostomies** have to be documented every year. ● Never miss the opportunity to capture conditions that are **permanent/semi-permanent/chronic** including amputations and ostomies.	● Refer to the 2019 HCC Coding and Documentation Tip sheet and Provider HCC Risk Adjustment Diagnosis Correct Coding Guide
General Coding	**Historic conditions**	● If the provider is **managing, evaluating, assessing, treating, planning, or referring** for the condition, then the condition is considered **active/current** and should be documented as a **current condition.** ● Unless the condition is **resolved and is not expected to ever return.** ● If monitoring for the condition is not occurring, **do not document "history of…"**	● Refer to the 2019 HCC Coding and Documentation Tip sheet.
General Coding	**Asymptomatic Conditions**	● Anytime a condition is **monitored, measured, assessed, evaluated, treated**, or a referral is made for further care, this condition is considered an **active medical condition**, even if the condition is **stable or asymptomatic**.	**Common examples of these conditions include :** **A**. Cancer that is being treated with hormone therapy (or simply monitored for recurrence). **B.** Diabetes **C.** COPD **D.** CHF (systolic and diastolic), compensated or asymptomatic **E.** Angina, stable or asymptomatic. Continue documenting for patients pain free, due to CABG or stent **F.** Paroxysmal Atrial Fibrillation **G.** Stable and asymptomatic peripheral arterial (vascular) disease
General Coding	**Acute Conditions After <u>Hospitalization</u>**	● Some **acute conditions** can only be coded during **initial hospitalization or initial treatment**: **A**. Acute CVA **B.** Acute respiratory failure **C.** Acute coronary syndrome ● Other diagnoses are coded in **follow-up visits** as long as the conditions are **still present:** **A.** Gastroenteritis, Chron's disease **B.** Skin ulcer ● Most conditions that are **not being actively** monitored, assessed, evaluated, or treated require the use of **"history of…"** codes after the acute period. **A.** Z codes for "History of…" **B.** Z codes for status – amputation status, transplant status **C.** "Late effects of CVA" should be documented immediately after discharge. (**Reference Post-Acute Care for Stroke**) **D.** History of MI should be coded 5 weeks after the initial diagnosis of MI.	
General Coding	**Cancer**	● Consider **Cancer** as **active** unless it has **completely resolved** and is not expected to return. ● Annual check ups **do not qualify** for monitoring a resolved malignancy. ● If the cancer is **100% cured**, and **no further treatment or follow up is needed** other than an annual check up, then document **history** of cancer, otherwise, document the cancer as active.	**Lymphoma** is never documented as "History of lymphoma".
Infectious and Parasitic Diseases			
Infectious and Parasitic Diseases	**Chronic Hepatitis C**	Chronic **Hepatitis C** viral infection has historically been a devastating disease. Now there are effective treatments. ● The USPSTF recommends a **one-time screening** for HCV for all patients born between **1945-1965** and other persons at high risk for infection. ● 60-80% of **acute hepatitis C** patients develop **chronic hepatitis C**. ***** If this condition is suspected or if the patient has risk factors, then test and document the results, and treat as indicated.	

Category	Diagnosis	Documentation Tips	Notes
Neoplasms			
Neoplasms	**Neoplasms**	● Providers frequently do not have all the information needed to make a final diagnosis for Neoplasms. Consequently, an "**unspecified**" condition is reported while awaiting additional information. ● "**Neoplasm of uncertain behavio**r" is frequently used to document and describe a mass that is awaiting confirmatory biopsy results. This is an **interim diagnosis** not intended as a **final diagnostic code**, unless that is the final biopsy result (rare). ● **Neoplasm of uncertain behavior**, **unspecified** should be used based on **pathology** or **histology report** stating behavior is uncertain or unpredictable and not used for an unknown neoplasm while pending confirmation.	
Neoplasms	**Metastatic Cancer**	● Metastatic Cancer is a condition that **requires specialty care** provided by an **oncologist**. ● The medical record should have the **primary site** of malignancy well documented as well as the **sites of the metastasis**. Both are absolutely **necessary** for care considerations.	
Neoplasms	**Cancer**	● Consider **Cancer** as **active** unless it has **completely resolved** and is not expected to return. ● Annual check ups **do not qualify** for monitoring a resolved malignancy. ● If the cancer is **100% cured**, and **no further treatment or follow up is needed** other than an annual check up, then document **history** of cancer, otherwise, document the cancer as active.	**Lymphoma** is never documented as "History of lymphoma".
Blood and Blood-Forming Organs			
Blood and Blood-Forming Organs	**Senile Purpura**	● Senile Purpura is **common** in patients **over 65**. ● These lesions or "spots" are commonly referred to as solar, actinic, or Bateman purpura. They **appear on sun-damaged skin** forearms, dorsal hands and are due to minor trauma causing ruptured blood vessels with extravasation of blood into the dermis.	● These lesions are **seen more frequently** in patients taking anticoagulants, antiplatelet agents, or corticosteroids. ● The discoloration **usually lasts 1-3 weeks**, and does not undergo usual color stages of normal bruise. However, residual hyperpigmentation may persist.
Blood and Blood-Forming Organs	**Secondary Hypercoagulable State**	● Secondary Hypercoagulable states can predispose to deep vein thrombosis. ● Conditions like antiphospholipid antibody syndrome, lupus, malignancy, and atrial fibrillation, medications, prolonged immobility can all predispose to developing inappropriate intravascular blood clots.	● Being aware of these factors can help clinicians guide therapy to avoid these deleterious health consequences.
Blood and Blood-Forming Organs	**Thrombophilia**	● Thrombophilia is a **hypercoaguable** state and should be noted as such in the medical record.	
Endocrine, Nutritional and Metabolic Diseases			
Endocrine, Nutritional and Metabolic Diseases	**Diabetes**	● Provider should indicate **clearly** if diabetes is **complicated or uncomplicated** (it is almost always complicated). ● Typical **complications of diabetes:** **A.** Nephropathy **B.** Retinopathy **C.** Neuropathy Conditions that are complications of diabetes should be described in the note. ●Diabetes with any of these **other complications** would be documented as "diabetes with other complication." **A.** Hypertension **B.** Hyperlipidemia **C.** Obesity **D.** Hyperglycemia/hyperosmolarity.	
Endocrine, Nutritional and Metabolic Diseases	**Diabetes with Complications**	● Documenting **diabetes with complications** requires using terms that specify diabetes as the **cause** of the complication (**linkage terms**), like "*diabetic*" or "*secondary to diabetes*." ● Diabetes with complications **may require two codes**: first the code for the diabetes, then the complication code. ● Documentation should **always** include Z-Codes to designate patients using *insulin* or a *family history* of diabetes.	

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Endocrine, Nutritional and Metabolic Diseases	**Ocular Complications of Diabetes**	● Diabetes is the **most common** cause of non-congenital vision loss in the United States. ● There are many **Ocular Complications of Diabetes** including: **A.** Cataracts **B.** Retinopathy **C.** Macular edema ● Cataracts are a common finding and have many etiologies. It is important to document and/or to begin treatment for diabetes mellitus with a diabetic cataract every time these conditions are observed in clinic.	● The American Diabetic Association recommends **all diabetics undergo an annual comprehensive eye exam** by an ophthalmologist or optometrist, including a dilated retinal examination.
Endocrine, Nutritional and Metabolic Diseases	**Type 2 Diabetes Mellitus with Other Specified Complication**	● The diagnosis of Type 2 Diabetes Mellitus with **Other Specified Complication** is used to document care for patients with complications of diabetes other than those related to diabetes associated with ophthalmologic, neurologic, renal, or vascular processes. ● Some **other manifestations** may include but are not limited to: **A.** Hypertension **B.** Obesity **C.** Hyperlipidemia **D.** Coronary Disease **E.** Hypoglycemia **F.** Muscular findings including Dupuytren's Contracture **G.** Skin and nail findings including onychomycosis	
Endocrine, Nutritional and Metabolic Diseases	**Diabetes with Cardiovascular Complications**	● Documentation / Linking / Coding Tip **A.** Clearly **link** the diabetes and the circulatory complication. **B.** **Documen**t an assessment and plan for both the diabetes and the complication **C.** If you are **coding**, be sure to use the correct ICD-10-CM code	Refer to the 2019 HCC Coding and Documentation Tip sheet.
Endocrine, Nutritional and Metabolic Diseases	**Insulin**	● Documentation of the **long-term (current) use of insulin** demonstrates the increased complexity of patients who require this medication, with its associated support mechanisms and team.	● CMS recognizes that when introducing, managing, or adjusting insulin for the chronic management of diabetes, additional time and care must be attributed to ensure the understanding, compliance, and most of all, the safety of diabetic patients.
Endocrine, Nutritional and Metabolic Diseases	**Obesity**	● Obesity due to **excess calorie** intake should be diagnosed. If the obesity is due to excess calorie consumption or decreased calorie expenditure. ● **Avoid** simply writing “obesity” as this diagnosis is not clinically accurate and maps to a code that does not risk adjust.	
Endocrine, Nutritional and Metabolic Diseases	**Morbid Obesity**	● Morbid Obesity refers to patients with a **BMI (body mass index)** value of **≥40 or ≥35** with an obesity **related complication** including: DM, HLP, HTN, sleep apnea, CAD, or other PAD/PVD (NIH NHLBI Obesity Education Initiative). ● Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. ● Documenting “morbid obesity” is not adequate. Providers should be as specific as possible and document the etiology.	● Many providers are reluctant to document obesity as **“morbid” or “severe”** due to a desire not to offend patients. Yet, patients need to accurately understand their conditions, and providers need to be appropriately reimbursed for the care they provide. ● In extreme cases, especially when medical **treatment is not sought**, morbid obesity can lead to pulmonary hypertension, right-sided heart failure, and ultimately death.
Endocrine, Nutritional and Metabolic Diseases	**Hyperparathyroidism**	● Hyperparathyroidism is a condition that results in **abnormal electrolyte levels** that are frequently noted on screening labs. While the type of hyperparathyroidism may require specialist assistance (**endocrinology or nephrology**), the diagnosis should be documented. ● **Secondary hyperparathyroidism** is commonly noted with **CKD** and should be properly diagnosed so disease-modifying agents can be initiated.	National Kidney Foundation Guidelines: ● Check CKD 3, 4 and 5 patients for PTH, calcium and phosphorus1 A. CKD 3 – every 12 months B. CKD 4 – every 3 months C. CKD 5 – every month ●1KDIGO “Clinical Practice Guidelines for Bone Metabolism and Disease in Chronic Kidney Disease” recommends testing for bone disease and disorders of calcium and phosphorus
Endocrine, Nutritional and Metabolic Diseases	**Hyperhomocysteinemia**	● Hyperhomocystine levels can be **associated with poor health outcomes**. Document this condition in the medical record if noted.	

Category	Diagnosis	Documentation Tips	Notes
Mental, Behavioral and Neurodevelopmental Disorders			
Mental, Behavioral and Neurodevelopmental Disorders	**Depression**	● **Do not** routinely document "**depression**", as this one-word diagnosis refers to a code that does not risk adjust and is most likely clinically inaccurate. ● **Be specific** with the depression diagnosis, and do not use the word "**unspecified**" if there is documentation in the note indicating what type of depression is truly present (**use a PHQ2/9 and medication history as documentation of status**). ● Document whether the major depressive disorder or is "**mild/moderate/severe**", "**complicated/uncomplicated**", and "**with or without psychosis.**"	● Use a (PHQ) – 2 or 9 and medication history as a documentation status. ● Refer to our Behavioral Health Screening Tools Pocket Reference. These tools can be found in HealthCare Partner's website.
Mental, Behavioral and Neurodevelopmental Disorders	**Major Depressive Disorder**	● Appropriate documentation of major depressive disorder requires that: **A. Duration** is specified (single episode vs. recurrent depression) **B. Severity** is indicated (mild, moderate, or severe) **C. Presence** of any psychotic symptoms are conveyed **D. Degree** of resolution, partial or full remission, be documented. ● The PHQ-2 is just the first two questions of the PHQ-9, and if they are negative, the provider can choose to stop at that point, as the PHQ-9 will most likely be negative.	● The Patient Health Questionnaire (**PHQ**) – 2 or 9 are instruments for screening, diagnosing, monitoring and measuring the severity of depression. ● These questionnaires are diagnostic measures for major depression. They can be administered repeatedly – reflecting improvement or worsening of depression in response to treatment. ● Documenting antidepressant medication usage is important as HEDIS measures include usage rates at 12 weeks and 6 months for newly diagnosed and treated Medicare and Medicaid patients. ● Refer to our Behavioral Health Screening Tools Pocket Reference. These tools can be found in HealthCare Partner's website.
Mental, Behavioral and Neurodevelopmental Disorders	**Alcohol Use Disorder**	● **DSM-IV** (Diagnostic and Statistical Manual of Mental Disorders) outlined separate diagnostic criteria for alcohol **dependence** and alcohol **abuse**. ● **DSM-V** (Diagnostic and Statistical Manual of Mental Disorders) has **combined** these two conditions into **one diagnosis**, Alcohol Use Disorder (AUD). ● **DSM-V** characterizes **AUD** (Alcohol Use Disorder) as a problematic pattern of alcohol use leading to clinically significant impairment or distress as manifested by multiple **psychosocial, behavioral, or physiologic** features, and use that has features described by the **DSM-V criteria**. ● **DSM-V** further breaks down the disorder **severity** into **mild** (2-3 symptoms), **moderate** (4-5 symptoms), and **severe** (6 or more of the 11 criteria). It also groups **remission** into two categories: **early remission** (3-12 months of no symptoms other than cravings), and **sustained remission** (12 or more months of no symptoms other than cravings). ● For documenting providers, **alcohol abuse** correlates to **mild AUD**, and a**lcohol dependence** correlates with **moderate and severe AUD**. ● Alcohol use is any other use that is characterized by: A. Amounts that **result** in the risk of health consequences. B. Amounts that **already** resulted in health consequences. C. Meets some of the DSM-V AUD criteria but no diagnosis of abuse or dependence.	● The **CAGE** Questionnaire is an effective tool in assessing alcohol abuse and dependence. ● The tool is **not diagnostic**, but is **indicative** of the existence of alcohol use disorder. A **positive screen** must be followed by a clinical assessment to determine diagnosis. ● Refer to our Behavioral Health Screening Tools Pocket Reference. These tools can be found in HealthCare Partner's website. ● For optimal ICD-10-CM coding, there are other factors that need documented: A. Associated intoxication, withdrawal , delirium, or dementia. B. Associated psychotic, anxiety or mood disorder. C. Associated sexual dysfunction or sleep disorder. D. Any other unspecified disorders or complications.
Mental, Behavioral and Neurodevelopmental Disorders	**Bipolar I Disorder, manic episode**	● A **manic episode** that emerges during antidepressant treatment, but persists at a fully **syndromal level** beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a **bipolar I diagnosis**. ● A distinct period of abnormally and persistently elevated, expansive or **irritable mood** and abnormally and persistently i**ncreased goal-directed activity or energy**, lasting at least one week and present most of the day, nearly every day. ● During the period of **mood disturbance** and **increased energy or activity**, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior: **A.** Inflated self-esteem or grandiosity. **B.** Decreased need for sleep. **C.** More talkative than usual or pressure to keep talking. **D.** Flight of ideas or subjective experience that thoughts are racing. **E.** Distractibility, as reported or observed. **F.** Increase in goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation. **G.** Excessive involvement in activities that have high potential for painful consequences. **H.** The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features. **I.** The episode is not attributable to the physiological effects of a substance or to another medical condition.	● The Mood Disorder Questionnaire (**MDQ)** is an effective **screening tool** for bipolar disorder. It is **not diagnostic**, but indicative of bipolar disorder. A positive screen must be followed by a clinical assessment to determine diagnosis.

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Mental, Behavioral and Neurodevelopmental Disorders	**Schizophrenia**	DSM-V diagnostic criteria for Schizophrenia requires: ● T**wo or more** of the following are to be present for a significant portion of time during a one-month period. At least **one** of these must be (a), (b), or (c): **A.** Delusions **B.** Hallucinations **C.** Disorganized speech **D.** Grossly disorganized or catatonic behavior **E.** Negative symptoms ● **Continuous signs** of the disturbance persist for at least **six months**. This six month period must include at least one month of symptoms that meet Criterion A and may include periods of prodromal or residual symptoms. ● Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out. ● The disturbance is not attributable to the psychological effects of a substance or another medical condition	
Circulatory and Cardiovascular System			
Circulatory and Cardiovascular System	**Diastolic Dysfunction CHF**	● Documenting every grade of **CHF**, even grade 1, is appropriate under **CMS guidelines**. ● The American Heart Association and the American College of Cardiology have recommended that **all types and stages of CHF** be documented as clinically relevant and treated, including grade 1 diastolic dysfunction.	
Circulatory and Cardiovascular System	**Myocardial Infarction**	● Acute MI (**Myocardial Infarction**) can be coded for **up to four weeks after discharge**. The provider should always be as specific with the **site** of the **M**I when coding the **acute condition** (Myocardial Infarction, LAD, without heart failure). ● A provider should code **old MI** (Myocardial Infarction) four weeks after discharge. ● Both **STEMI** and **NSTEMI** can be coded as **old MI after resolution**.	
Circulatory and Cardiovascular System	**Hypertensive Heart Disease**	● Hypertensive Heart Disease is a **non-specific diagnosis** used to describe cardiac conditions associated with hypertension. These included CAD, LVH, and CAD. ● ICD-10-CM requires that clinicians **document** the following: A. The **status** and **type** of any heart failure **present** **B.** The **stage** of any **chronic kidney** disease **present**. It is necessary to document the type of CHF and CKD in separate diagnoses/codes as well.	● **Accurate, specific, and complete documentation** of hypertensive heart disease is important for providers and patients, as thorough documentation should trigger measurement of quality measures associated with improved outcomes. ● The quality measures related to this condition include documentation of controlling blood pressure, the annual measurement of potassium and creatinine levels for patients on ACEs, ARBs, or diuretics. These may be used to assess a clinician's quality of care.
Circulatory and Cardiovascular System	**Peripheral Arterial/Vascular Disease**	● Peripheral Arterial/Vascular Disease assessment by **measurement of the ankle-brachial index** (ABI) is reasonable if peripheral arterial disease (PAD), also known as peripheral vascular disease (PVD), is suspected. ● ABI Interpretation: ≤0.90 – Abnormal and diagnostic for PAD2. ● Atherosclerotic vascular disease is a **chronic, progressive** disease that should be referred to as **current or known** PAD/PVD, **not history** of PAD/PVD3.	● Although, the majority of patients with PAD will not have symptoms, **clinical reasons to suspect PAD** include claudication, a non-healing ulcer, skin changes including hair loss over the lower legs, diabetes, hypertension, history of smoking, and age >70.
Circulatory and Cardiovascular System	**Heart Failure**	● ICD-10 requires providers address the following: A. **Etiology** of the Heart Failure B. Whether the Heart Failure is **systolic, diastolic, or combined systolic and diastolic** **C. Chronicity** (acute, chronic, or acute on chronic). ● **Treatment** should start as soon as HF is accurately diagnosed, and associated symptoms including HTN, DM, Afib, pulmonary hypertension and obesity should be assessed and treated.	● **Heart Failure** (HF) is a condition that can result from any functional or structural cardiovascular disorder that results in inadequate systemic perfusion, not meeting the metabolic demands of the body. The diagnosis is usually suspected clinically, and **confirmed with an echocardiogram**. Systolic and/or diastolic HF may be identified. ● **Accurate, specific, and complete documentation** of HF is important because thorough documentation should trigger quality measurements associated with improved outcomes.
Circulatory and Cardiovascular System	**Angina Pectoris**	● Angina Pectoris can be difficult to diagnose and **requires clinical suspicion and diagnostic testing** for evidence of ischemic heart disease. Yes, angina pectoris can be characterized by chest pain, but it is so much more as chest pain is a non-specific symptom. ● If a provider suspects a cardiac diagnosis, then the studies should be obtained and the diagnosis of angina pectoris made if the pain has a cardiac etiology.	
Circulatory and Cardiovascular System	**Aortic Ectasia**	● Aortic Ectasia is a **common finding** associated with hypertension and aging and often noted with an aortic rood dilatation. It is **not an aneurysm**, but should still be documented given the associated possible complications.	

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Circulatory and Cardiovascular System	**Deep Vein Thrombosis (DVT)**	● Acute and Chronic **Deep Vein Thrombosis** are conditions that require aggressive treatment and close monitoring. ● Providers should **initiate and continue treatment** following guidelines applied to the individual needs of the patient. The conditions to guide this therapy are many and should all be recorded in the medical record.	
Genitourinary System			
Genitourinary System	**Kidney Failure**	● Only **stages three, four, five, and ESRD/on hemodialysis** are risk adjustable codes. ● All stages of CKD create an interaction factor with other chronic conditions. This interaction results in an increased risk adjustment factor.	
Genitourinary System	**Chronic Kidney Disease**	● **Chronic Kidney Disease** (CKD) is a condition that can be the result of other disease processes like hypertension (HTN) or diabetes (DM). **To appropriately document** hypertensive CKD or diabetic CKD in ICD-10-CM, a provider must identify and document the etiology of the CKD.	
Genitourinary System	**Dialysis**	● **Document** the **stage of the CKD** (stages 1-5). ● **Document** if the patient has CKD stage 5, but not yet requiring or electing dialysis. ● **Do not** use CKD stage 5 if the patient has ESRD and is on dialysis. ● Document **end stage renal disease** if the patient has CKD stage 5 and requires dialysis. ● Document the **Z code** for **dependence on renal dialysis** for patients on dialysis after also documenting end stage renal disease. These conditions/status need to be documented together in the medical record.	
Nervous System			
Nervous System	**Peripheral neuropathy, General Neuropathy, and Radiculopathy**	● Peripheral neuropathy, general neuropathy, and radiculopathy are **vague terms** that have various etiologies resulting in similar symptoms. **It is important to be as specific as possible** with this diagnosis, and to document the **underlying** causative or associated conditions. ● Polyneuropathy in **diseases classified elsewhere** should be used when the symptoms are associated with most underlying diseases. Hereditary and idiopathic neuropathy, unspecified, and polyneuropathy, unspecified are used for POLY-neuropathy of unknown or unspecified cause, not for radiculopathy. ● If the pain is chronic and not clearly associated with a neuropathic or radicular process, **consider diagnosing as chronic pain**, not elsewhere classified.	
Nervous System	**Peripheral Mononeuropathy and Polyneuropathy**	● Peripheral mononeuropathy and polyneuropathy are **common Neurological Complications of Diabetes**. ● Diabetes with neurological manifestations can also be associated with cardiovascular autonomic neuropathy, which may present as tachycardia and postural hypotension.	● Additional diabetes associated autonomic neuropathic diagnoses include: A. Bladder dysfunction B. Sexual dysfunction C. Gastroparesis ● Examples of diabetes associated mononeuropathy include: A. Bell's palsy B. Ulnar neuropathy C. Meralgia paresthetica D. Diabetic polyradiculopathy E. Carpal tunnel Syndrome
Nervous System	**Drug-Induced Myopathy**	● This **condition should be documented** in the medical record to avoid further medication induced complications.	● Drug-Induced Myopathy is frequently associated with myalgias, myositis, other muscle disorders, and even rhabdomyolysis.
Nervous System	**Drug-Induced Neuropathy**	● This condition should be documented in the medical record to avoid further medication induced complications.	● Drug-Induced Neuropathy is a frequent complication given the many routinely used medications associated with this condition. Amiodarone, phenytoin, hydralazine, metronidazole, nitrofurantoin, and antineoplastic agents are some of the offending agents.
Musculoskeletal System and Connective Tissue			
Musculoskeletal System and Connective Tissue	**Sacroilitis**	● Sacroilitis can be suspected clinically and diagnosed with a supporting X-Ray showing changes of at least Grade 2 bilaterally (minimal changes) or Grade 3 (unequivocal changes) unilaterally.	
Respiratory System			
Respiratory System	**Interstitial Lung Disease**	● Intersitial Lung Disease should be **diagnosed and treated as early as possible** given the progression of the disease. ●CXRs are not diagnostic, so HRCTs and PFTs are obtained. These conditions should be documented in the medical record with as much specificity as possible.	
Respiratory System	**Pulmonary Fibrosis**	● Pulmonary Fibrosis should be diagnosed and treated as early as possible given the progression of the disease. ● CXRs are not diagnostic, so HRCTs and PFTs are obtained. These conditions should be documented in the medical record with as much specificity as possible.	

Category	Diagnosis	Documentation Tips	Notes
Documentation Guide			
Documentation Guide	**Medical Record Validation**	●What **should** a medical record have: A. Provider name B. Provider Signature C. Provider Credentials D. Date of service E. Member First and Last name F. Member Date of birth G. Two patient identifiers on each page (Name and Date of Birth) ● Most **electronic health records** contain this information and insert it automatically. However, when filling out hand written forms for health plans or other managed-care organizations, it is crucial that this information has been documented on the chart and verified as accurate.	
Documentation Guide	**Amending a Progress Note**	● The Centers for Medicare & Medicaid Services (**CMS**) guidelines recommend that patient **encounters should be documented at the time of service or shortly thereafter.** Delayed entries may be reasonable for up to **24-48 hours**. After the initial documentation/coding of an encounter, there may arise a need to amend the medical record. Errors requiring clarification and correction may be found by the provider, coder, nurse, office staff, or even the patient. ● CMS (Medicare Program Integrity Manual) has provided guidelines for amending a progress note. Yet, a clear cutoff point was not given. Descriptions like "**timely**" and "**within a few days**" are used. Making it more complex, institutions and organizations frequently have their own internal rules and timelines.	● The CMS Medicare Program Integrity Manual, Pub. 100-08, chapter 3, section 3.3.2.5 clarifies that an auditor can give "less weight" to entries over 30 days, and can report a pattern of delayed entry. The best policy is to document as completely and as timely as possible.