oscar

CLINICAL DOCUMENTATION

Provider Coding Tips

ACTIVE DIAGNOSES

- All documented active conditions should be coded, along with the reason for the visit, to show the true medical complexity of the patient and the increased clinical decision making.
- The medical record from each encounter must "stand alone." Any details from previous encounters must be documented by the visit provider within the current DOS in order to code.
- Only physician and advanced practitioner documentation may be coded.
- Diagnoses can be coded from physician documentation anywhere in the encounter as long current clinical evidence is detailed for the condition.
- Diagnoses for coding may be abstracted from the chief complaint, HPI, relevant medical, social and family history, allergies, review of systems, physical examination, conclusions or impressions and treatment plan as long as they are validated by clinical evidence in the encounter.
- Additional diagnoses should be coded if they affect patient care and are documented in the clinical evaluation or with therapeutic treatment.

DIAGNOSTICS

- Documentation of an abnormal lab value should only be coded when it maps directly to a reportable diagnosis in ICD-10. (Example: documentation of "low sodium," etc., is not codable; hyponatremia must be stated.)
- Results of tests, x-rays, echocardiogram, pathology reports, etc., must be interpreted and documented by the physician treating the patient in the encounter. They cannot be coded directly from the test results or from another professional even when embedded in the current note.

SPECIFICITY

- Ensure to code the most specified representation of the condition documented; include etiology and severity of the condition when code selection allows. When acuity is documented, the code specificity should reflect this when it can.
- Coding is not allowed to make assumptions and only the exact documented terminology may be coded. Specificity cannot be abstracted from clinical data and must be interpreted and linked to further define the condition.
- When causal relationships are documented, this should be represented in the code specificity. (e.g. diabetic neuropathy, pancytopenia due to chemotherapy, etc.)
- In cases where an infecting organism is documented, it should also be coded.

HISTORICAL AND UNCONFIRMED DIAGNOSES

- A diagnosis that is documented as personal history, PMH, or from a problem list is not considered active unless restated in the current assessment with evidence of presence. Conditions not brought current in the encounter can only be coded using a related Z (history of) code.
- If a condition is documented with clinical evidence that suggests it as resolved, or no clinical evidence present, this must be coded as a personal history as it cannot be confirmed as an active condition.
- Uncertain diagnoses ("possible," "probable," "suspected," "likely," "questionable," "still to be ruled out" or other similar terms) cannot be coded in an OP setting and instead symptoms should be coded.
- Diagnoses that are "ruled out" or still being investigated are not coded.