oscar

CLINICAL DOCUMENTATION

Active and Historical Diagnoses

Complete and compliant documentation can serve to improve quality and continuity of care, enhance communication of the patient's health and care needs, and increase patient safety. Added benefits for providers and organizations can include improved decision making, consistent data, enhanced accuracy, increased revenue and legal protections.

ACCURATE DIAGNOSIS STATUS IMPORTANCE:

Documenting a diagnosis in the health record extends beyond its impact on reimbursement and quality-of-care measures. It is also critical to patient safety and care.

Discrepancies in active and historical status typically arise more often for longstanding chronic conditions. It is vital to document the current management for these diseases to show that being asymptomatic is the desired outcome of the treatment and the disease is indeed still present.

OFFICIAL GUIDANCE ICD-10-CM:

IV. J **Code all documented conditions that coexist**

Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

STATUS:

Active status

- Conditions that are present and unresolved or unlikely to resolve need to be addressed and documented at least annually.
- If a condition is managed on maintenance treatment with no present symptoms, it is considered controlled and should be documented as active.
- Documentation should convey that these conditions are still present with clinical evidence.
- A stable status must be further defined within the clinical documentation to show whether the condition is still present and controlled or stable as resolved.

"History of" or "Past" Conditions

- In ICD-10-CM coding language, "history of" means that the patient no longer has the condition, in which case it cannot be considered an active disease.
- CMS considers a condition resolved if not evaluated at least once per calendar year.
- Truly resolved and no longer present conditions can be explained as personal history to ensure additional care requirements are not missed.

DIAGNOSES TO ADDRESS:

Pertinent Conditions

- Chief complaint that necessitated the encounter
- Present but controlled
- Managed on therapy
- Requires monitoring
- Prompts referral to another provider
- Influences your decision making in care of the patient

Chronic Conditions

- Document chronic conditions annually, even when controlled with treatment
- Document severity/stage of condition including the acuity status
- Document associated conditions or complications and relationship to the underlying chronic condition

Status codes

- Substance-related disorders in remission
- Ostomies (that have not been reversed)
- Amputation
- Transplants
- Alcoholism in remission
- Mental health in remission
- Paraplegia/Quadriplegia
- Personal history of health events
  - History of stroke without sequelae
  - History of MI