Coding and Documentation Best Practices

Written by Angela Buckley, CCS, CPC, CPMA, CPC-I, RMA

TRICORE

- Documentation must support the diagnosis.
- If you Think It, Ink It, and then Link It.
- Use M.E.A.T to ensure the documentation supports the diagnosis:
  - **M**onitoring – signs, symptoms, disease progression, disease regression
  - **E**valuating – test results, medication effectiveness, response to treatment
  - **A**ssessing/Addressing – ordering tests, discussion, review records, counseling
  - **T**reating - medications, therapies, other modalities

- Do not use “history of” to describe a current or chronic condition that is still present, active, ongoing, or currently being treated. A history code indicates that the patient no longer has the condition.
- When an ICD-10 diagnosis code category has a code for “in remission” to describe a current condition in remission, use “in remission” rather than “history of” to aid in properly coding the condition.
- Report “history of” for conditions when the patient no longer has the condition and requires no further treatment.
- Know Local Coverage Determination (LCD) and National Coverage Determination (NCD) guidelines and requirements. They can change monthly so check them often for any changes.
- Having a current ICD-10 coding book in the office is helpful to assist in choosing the correct diagnosis and to make sure all required diagnoses are reported. Alternatively, there is a download for ICD-10-CM.
- ICD-10 Coding Guidelines are updated October 1st of each year and can be found online.

Resources

- CMS.gov for NCDs
  https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx

- Novitas Solutions for LCDs
  https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00024343

- ICD-10-CM Coding Guidelines
  https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf

- ICD-10 Coding Book download
  https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM