

Bridging language differences between clinical standards and coding guidelines is key for accuracy

Providers and coders rely on each other to perform their jobs efficiently and accurately; however, the two do not always speak the same language. This is partially due to the differences between clinical training and standards, and the ICD 10 coding guidelines that a coder must follow. This can lead to frustration and additional work for both parties. Following are some specific areas where differences exist and where efficiencies and accuracy can be gained.

Past medical history (PMH)

ICD 10 guidelines state “history of codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.” Providers often include a patient’s active and current conditions in documentation of the patient’s PMH. A coder cannot code conditions documented as PMH because, according to coding guidelines, they are historical and not current. The condition may be reported as a “history of” code, which may not be a true reflection of the patient’s status. Options to resolve this issue include the following:

- Clearly separate current and active patient conditions from PMH in patient documentation; or
- Include details within PMH that make it clear a condition is active and not historical. For example, stating, “the patient has a history of epilepsy which is currently well controlled with carbamazepine” makes it clear the condition is current.

Clinical findings and diagnosis coding

While a patient’s diagnosis seems obvious based upon laboratory or other diagnostic studies, a coder may not “code” a diagnosis based on clinical findings. Diagnostic coding must be based upon the provider’s specific documentation of that condition. Two examples of this include:

- A patient with chronic kidney disease has a glomerular filtration rate reported as 30 at a clinic visit. While this supports the patient’s chronic kidney disease is stage 3, a coder cannot select a chronic kidney disease stage 3 diagnosis code without provider documentation of “chronic kidney disease stage 3.”
- An oxygen dependent patient with emphysema has both hypoxia and hypercapnia documented at an outpatient clinic visit. While the provider knows this patient has chronic respiratory failure, a coder cannot assume and code this diagnosis unless the provider states “chronic respiratory failure.”

Acronyms

The use of acronyms in documentation can pose an issue for diagnosis coding. A coder cannot assume an acronym indicates a specific diagnosis. Some examples where this can significantly

impact diagnosis coding include the following:

- CRF – Chronic Respiratory or Chronic Renal Failure
- CVD – Cardiovascular or Cerebral Vascular Disease
- CAD – Coronary Artery or Carotid Artery Disease

Options to resolve this include the following:

- Adhere to your facility's approved abbreviations listing. This abbreviations list can be referenced if your documentation comes into question.
- Spell out the diagnosis in complete words, followed by the acronym in parentheses, when initially used in your document; then continue to use the acronym.

Cancer – Active versus historical

From a clinical perspective, a patient is often considered to have active cancer from the time of diagnosis, through treatment and the years following while they are monitored for recurrence. ICD 10 coding guidelines differ from clinical practice, however, and must be followed from a coding perspective. Following coding guidelines for the diagnosis of cancer does not mean that a provider should alter cancer surveillance of their patient from recommended clinical standards.

Active cancer is diagnosed when the following criteria are met:

- The patient has evidence of current disease.
- The patient is receiving treatment for cancer.
- The patient declined treatment or did not receive treatment due to another reason.

"History of" cancer is the correct diagnosis when the patient does not meet one of the above criteria for active cancer.

Additional information about risk adjustment and Hierarchical Condition Categories (HCC) coding is available at www.securityhealth.org/hcc.