

Keystone Mercy Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Review

What is the Risk Score Adjustment Model?

The Department of Public Welfare (DPW) utilizes medical encounter data supplied by Keystone Mercy to evaluate disease severity and risk of increased medical expenditures. DPW employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-based capitation payments to Keystone Mercy. Accurate payments from DPW help us ensure that providers are reimbursed appropriately for services provided to our members.

- *We must obtain health status documentation from the diagnoses contained in claims data.*

Why are retrospective chart reviews necessary?

Although Keystone Mercy captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

What is the significance of the ICD-9-CM Diagnosis code?

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are identified as 3 to 5 digit codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes (V10-19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-9-CM Official Guidelines for Coding and Reporting (October, 1, 2010), providers must code all documented conditions that were present at time of the encounter/visit, and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the member?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

Amputation status	Diabetes mellitus	Multiple sclerosis
Bipolar disorder	Dialysis status	Paraplegia
Cerebral vascular disease	Drug/alcohol psychosis	Quadriplegia
COPD	Drug/alcohol dependence	Renal failure
Chronic renal failure	HIV/AIDS	Schizophrenia
Congestive heart failure	Hypertension	Simple chronic bronchitis
CAD	Lung, other severe cancers	Tumors and other cancers
Depression	Metastatic cancer, acute leukemia	(Prostate, breast, etc.)

What are your responsibilities?

Physicians must accurately report the ICD-9-CM diagnosis codes to the highest level of specificity.

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:
 - 250.60 Diabetes with neurological manifestations and 357.2 for diabetic polyneuropathy

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation is clear; concise, consistent, complete, and legible.

Physician Documentation Tips

- ✓ First list the ICD-9CM code for the diagnosis, condition, problem or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- ✓ Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- ✓ Strike through, initial, and date. Do not obliterate.
- ✓ Use only standard abbreviations.
- ✓ Identify patient and date on each page of the record.
- ✓ Ensure physician signature and credentials are on each date of service documented.
- ✓ Update physician superbills annually to reflect updated ICD-9CM coding changes, and the addition of new ICD-9CM codes.

Physician Communication Tips

- When used, the SOAP note format can assist both the physician and record reviewer/coder in identifying key documentation elements.

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

Objective: Data obtained from examinations, lab results, vital signs, etc.

Assessment: Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.

Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

For more information contact Provider Services at 1-800-521-6007 or your Keystone Mercy Provider Account Executive.