TABLE OF CONTENTS

MEDICARE DOCUMENTATION AND CODING REQUIREMENTS

MEDICARE DOCUMENTATION AND CODING REQUIREMENTS ........................................... 9-1
  IMPORTANT REMINDER ........................................................................................................ 9-1

MEDICAL RECORD DOCUMENTATION AND EVALUATION REQUIREMENTS .......... 9-1
  IMPORTANT REMINDER ........................................................................................................ 9-2
  DOCUMENTATION AND CREDENTIALS REQUIREMENTS .................................................... 9-2

MEDICARE ICD-9-CM CODING REQUIREMENTS ............................................................ 9-4
  QUALITY CODING PRACTICES ............................................................................................ 9-4
  IMPORTANT REMINDER ........................................................................................................ 9-7

QUICK REFERENCE TIPS .................................................................................................... 9-7
  IMPORTANT REMINDER ........................................................................................................ 9-8

WEB RESOURCES .................................................................................................................... 9-8
MEDICARE DOCUMENTATION AND CODING REQUIREMENTS

Alliance CompleteCare is required to submit to the Center for Medicare and Medicaid Services (CMS), all necessary data that characterizes the context and purpose of each face-to-face encounter between a Medicare enrollee and a physician/practitioner, supplier, or other provider. Your role as an Alliance CompleteCare Provider or Delegate is to accurately report all symptoms, identifiable conditions, and co-morbidities, in the provider and hospital medical records, and on submitted claims. Failure to document diagnoses in the provider and hospital medical records, and submit claims for these services at the highest level of ICD-9-CM specificity, will result in lower reimbursement to the health plan. Alliance CompleteCare allows providers to annually assess their patients through coverage of an annual physical examination.

The Alliance will ensure that codes submitted to CMS are complete and accurate, by conducting provider and delegate medical record audits. Medical record notes should be as complete and accurate as possible, so you can provide the best care to Alliance members. Good documentation assures that all of the patient’s medical conditions are addressed.

Important Reminder

Alliance CompleteCare will conduct an audit of your claims and medical records for appropriate and complete coding of all diagnostic conditions at least twice a year.

MEDICAL RECORD DOCUMENTATION AND EVALUATION REQUIREMENTS

Managing patient care and reporting services rendered is the critical role providers play in documenting their face-to-face encounters with patients. Basic documentation should always include thorough documentation of all conditions evaluated, monitored, or treated, reason for the visit, care rendered, conclusion, and diagnosis. In addition, the provider should always document chronic diseases, disease interactions, complications and manifestations, late effects, conditions that co-exist at the time of encounter and conditions that require or affect patient
care, treatment, or management. Providers are not required to document conditions that were previously treated or no longer exist, unless the previous conditions impact current care or influence treatment.

**Important Reminder**

Providers must document all conditions evaluated, monitored, or treated during a face-to-face encounter with a patient. Alliance CompleteCare covers an annual physical examination to assist providers in assessing and documenting patients’ health annually.

**Documentation and Credentials Requirements**

Alliance CompleteCare providers are required to document as follows:

- Only authorized medical staff may document face-to-face encounters in the patient’s record. Authorized medical staff includes physicians, nurse practitioners, nurse anesthetists, physician assistants, and certified midwives.
- Ensure documentation is clear, concise, consistent, complete, and legible.
- Provider should use the standard SOAP note format when documenting the patient’s charts as identified below.
  - Subjective – how the patient describe their problem
  - Objective – Data obtained from examinations, lab results, vital signs, etc.
  - Assessment – Listing of the patient’s current condition and status of all chronic conditions. How the objective data relate to patient’s acute problem
  - Plan – Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up
- Provider medical record notes must support all diagnoses coded on the claim for the date of service. Listing diagnoses is not sufficient. The record must indicate that the provider monitored, evaluated, or treated the condition.
- Use only standard abbreviations and keep them to a minimum. Provider offices should have a standard abbreviations list.
- Every page of the medical record must identify the patient by name, and the date of service.
- The person who documents the medical record must be clearly identified. The signature identified should be a legible printed name with the provider’s credentials and date on the medical record notes.
The signature should be identified at least once per entry in the record.

If the provider’s signature is not legible, there should be a signature log with the physician’s printed or typed name, credential, and legal signature. If the provider has different signatures, the variations on his/her signature should reflect this in the log. See example below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Credential</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>D.O. (Doctor of Osteopathic Medicine)</td>
<td></td>
</tr>
<tr>
<td>John Doe</td>
<td>D.O. (Doctor of Osteopathic Medicine)</td>
<td></td>
</tr>
</tbody>
</table>

CMS states Electronic Medical Records (EMR) require an authenticated electronic signature indicated on the medical record. Acceptable electronic signatures include one of the statements below followed by the provider signature:

- Electronically Signed By
- Authenticated By
- Approved By
- Validated By
- Completed By

Providers using alternative signature methods (e.g., signature stamp) bear the responsibility for the authenticity of that information being attested to. CMS maintains strict policy on signature; therefore, physicians should use the following guidelines:

- Offices should have a policy and procedure related to the use of signature stamp.
- Providers should secure the signature stamp in a locked location.
- Only the provider should have access to the signature stamp.

Regarding the office visit, only notes signed by the physician, nurse practitioner, nurse anesthetists, physician assistants, and certified midwives, reflecting face-to-face contact with the patient and direct attention to the diagnosis in question, are valid for documentation.

Providers should document clinical impressions derived from other sources such as, lab values, radiology reports, pathology reports, and hospital and consult notes, in the medical record note.
• When pre-printed stationery is used for medical record documentation, and the provider of service is not listed on the stationery, then the credentials must be part of the signature for that provider. This way CMS can determine that the beneficiary was evaluated by a provider or an acceptable provider data source.

• Superbills are not considered sufficient documentation of clinical conditions.

**MEDICARE ICD-9-CM CODING REQUIREMENTS**

The quality of diagnosis coding is important to appropriately and accurately identify the member’s health status. Alliance CompleteCare providers are required to assess the health status of their patients at least annually, in a face-to-face visit, and report all relevant diagnoses in the chart, and during the billing process. All face-to-face provider encounters should be coded to the highest level of ICD-9 specificity. The highest degree of specificity is the practice of assigning the most precise ICD-9-CM code that most fully explains the narrative description documented by the provider in the medical chart or hospital record of the symptoms or diagnoses.

**Quality Coding Practices**

Alliance CompleteCare providers should follow the guidelines below to ensure quality coding:

<table>
<thead>
<tr>
<th>Assessments:</th>
<th>Initial Health Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Health Assessment</td>
<td>• Alliance CompleteCare providers are required to complete an initial health assessment within 90 days of member assignment to your practice.</td>
</tr>
<tr>
<td>Annual Physical Exam</td>
<td>Annual Physical Exam:</td>
</tr>
<tr>
<td></td>
<td>• The Alliance CompleteCare benefit package includes coverage of an annual physical examination to assist providers in their annual assessment of a member’s health status.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding Books</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Use current ICD-9-CM books updated by the American Medical Association (AMA) yearly in October.</td>
</tr>
<tr>
<td></td>
<td>• Access new ICD-9-CM codes from the CMS website.</td>
</tr>
<tr>
<td></td>
<td>• Updated office super bills annually with current ICD-9 codes.</td>
</tr>
</tbody>
</table>
### Coding Specificity
- Specificity means coding a condition using the most precise ICD-9 code that fully explains the written description of the condition in the patient’s medical chart.
- Code all face-to-face encounters to the highest level of ICD-9 specificity.
- Do not code probable, suspected, questionable, rule out, or working diagnoses. Code the actual condition to the highest degree of certainty for that visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.

### Coding Terms
- When the terms code also, code first, or use additional code, are included in the ICD-9-CM manual for a particular code, follow the instructions to fully code the patient’s condition.

### Chronic or Ongoing Conditions
- State that conditions are chronic versus acute, or unspecified, for example, chronic renal insufficiency versus renal insufficiency.
- Use dependence diagnoses versus abuse diagnoses, such as alcohol dependence.
- Specify the type of condition, for example, plastic anemia versus anemia (NOS).
- The following chronic conditions always impact patient care or treatment and should be documented in the record and coded annually:
  - Diabetes Mellitus
  - Congestive Heart Failure
  - Asthma
  - Emphysema
  - Parkinson’s
  - Hypertension
  - Atrial Fibrillation, patient on Coumadin/Warfarin

  Note: The above is a sample of some common chronic conditions. Providers must document all chronic conditions annually.

### Combination Codes
- A combination code is a single code used to classify:
  - Two diagnoses
  - A diagnosis with an associated secondary process (manifestation)
  - A diagnosis with an associated complication
- Use the single code when it clearly identifies all of the elements documented in the diagnosis.
### Complications and Manifestations
- If a complication exists, code to the specific complication and manifestation, for example, code neuropathy due to diabetes. Use the ICD-9 code that shows the causal relationship.
- Code all documented conditions that co-exist at the time of the encounter that require or affect patient care, treatment, or management. Do not code conditions previously treated that no longer exist or affect current patient care or treatment.
- Use history codes when the condition impacts current care or treatment.

### Depression
- Document specificity such as major depression, use of anti-depressants, and single versus recurring events.

### Diabetes
- Code all complications and manifestations.
- Document direct causal relationships before diabetes and other diseases, for example, ulcer due to diabetes.

### Disease Interactions
- Certain combinations of co-existing diseases greatly impact a member’s health status. Providers must document in the medical chart and on a claim, completely and accurately, the following conditions annually:
  - Diabetes Mellitus/Congestive Heart Failure
  - Diabetes Mellitus/Cerebrovascular Disease
  - Congestive Heart Failure/Chronic Obstructive Pulmonary Disease
  - Chronic Obstructive Pulmonary Disease/Cerebrovascular Disease/Coronary Artery Disease
  - Rheumatoid Factor/Congestive Heart Failure
  - Rheumatoid Factor/Chronic Heart Failure/Diabetes Mellitus

  Note: The above list is a sample of some disease interactions only. Providers must document all disease interactions.

### History Codes
- Do not code conditions that were previously treated and no longer exist.
- Use history codes when the condition impacts current care or influences treatment.
### MEDICARE DOCUMENTATION AND CODING REQUIREMENTS

#### SECTION 9

| Late Effects | • Residual conditions that remain after the termination of the acute phase of an illness or injury, and should be coded if the medical record states, late, old, due to (a previous injury or illness), following (previous injury or illness), or traumatic (unless there is evidence of current injury). |
| Neoplasms | • Document the primary site, extension, invasion, or metastasis.  
| Protein-Calorie or Energy Malnutrition | • Code malnutrition specifically, and do not code weight loss as the diagnosis. |
| Old Myocardial Infarction | • Code healed or old myocardial infarctions currently presenting with no symptoms.  
• Document coronary artery disease. |
| Other Medical Documents and/or Notes | • Provider notes that reference diagnosis codes from other sources such as, lab, radiology, pathology, and hospital and consult notes must contain the provider’s clinical impression of the reports. |

---

**Important Reminder**

You can access new ICD-9-CM codes from the CMS website at:

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCode/07summarytables.asp

---

**QUICK REFERENCE TIPS**

- Primary care physicians must conduct an initial health assessment of all new patients within 90 days of enrolment to your practice.
- Primary care physicians must conduct an annual assessment exam on all patients.
- Fully document all chronic conditions at least annually.
- Document evaluation, monitoring and treatment activities in the medical record.
- Properly reflect the member’s health status and disease interactions by coding all conditions evaluated, treated, or monitored during each visit.
• Code to the highest level of ICD-9 code specificity.
• Ensure documentation is clear, concise, consistent and legible.
• Ensure provider signature is printed or typed on each chart entry with credentials and a legible signature.
• Ensure every page of the medical record identifies the patient by name and date of service.
• Ensure office staff understands the fundamentals of ICD-9 coding through proper training.
• Update code, books and superbills yearly in October when ICD-9-CM codes updated and released.

**Important Reminder**

| SOAP note format assist in both quality medical chart documentation and diagnoses coding. |

For questions or concerns, please contact the Alliance Provider Services Department.

**WEB RESOURCES**

http://cms.hhs.gov