

## Focus on specificity when documenting these four diagnoses

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Diagnosis codes convey the reason for the visit, and they also capture risk—something that many payers increasingly consider when calculating reimbursement. It's important for physicians to ensure that the information they document is as specific and complete as possible, said Terri Thomas, RHIA, clinical documentation specialist in San Leandro, Calif., who spoke during a recent national coding conference.

Accurate and complete documentation ultimately reduces denials, said Thomas. Translation? Physicians *retain* the revenue they generate.

Unspecified diagnosis codes often wreak havoc on cashflow because many payers simply deny them, said Thomas. "We need to be as specific and compliant as possible. That's one of the reasons why we moved to ICD-10," she said.

Thomas discussed these four diagnoses and provided checklists of what physicians should document to avoid denials:

### 1. Chronic obstructive pulmonary disease

- Body mass index
- Smoking status, including history of smoking, when applicable
- Use of home oxygen, BIPAP, or CPAP, when applicable
- With acute exacerbation, hypoxemia, bronchitis, asthma, emphysema, or upper respiratory infection, when applicable

### 2. Congestive heart failure

- History of myocardial infarction, coronary artery bypass graft, or smoking, when applicable
- Medication noncompliance, when applicable
- Presence of heart disease, bradycardia, heart block/type, arrhythmia, or diabetes, when applicable
- Severity (i.e., acute, chronic, or acute on chronic)
- Type (i.e., systolic, diastolic, left, right)
- Use of home oxygen, when applicable
- With hypertension or renal failure, when applicable

### 3. Diabetes

- Long-term insulin use, when applicable
- Manifestations and complications (e.g., nephropathy, retinopathy, osteomyelitis, and vascular disease), when applicable
- Medication noncompliance, when applicable
- Presence of secondary diabetes and cause (e.g., due to neoplasm, steroid-induced, or adverse effect of drugs), when applicable
- Relationship between diabetes and cellulitis, when present
- Type (i.e., Type 1 or Type 2)

#### 4. Hypertension

- Exposure to environmental tobacco smoke, when applicable
- History of myocardial infarction, coronary artery bypass graft, or any other cardiac condition, when applicable
- Medication noncompliance, when applicable
- Relationship with chronic kidney disease, congestive heart failure, or both, when applicable
- Tobacco dependence, use, or history of tobacco use, when applicable
- Type (i.e., emergency, urgency, or crisis)

Physicians must ensure that they document all conditions that coexist at the time of the encounter that require or affect treatment. Coders are obligated to query physicians when documentation is conflicting, ambiguous, or incomplete, said Thomas. Physicians can mitigate these queries and protect revenue by taking the time to learn the specificity that's required for code assignment.

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