Diabetes and Complications

When documenting diabetes, it's important to note the following:

- Type of diabetes, type 1 or type 2 or secondary.
- ICD-10 does not recognize type 1.5 and coding rules say it is to be coded as type 2.
- If secondary DM, document what the cause is or primary condition along with secondary diabetes.
- Is the diabetes CONTROLLED or UNCONTROLLED? "Poor control" must be coded as controlled diabetes as it is not specific.

Documenting Diabetic Complications

Causal relationships should be stated, not implied. Use phrases such as "due to" "because of" or "related to" to establish a clear relationship.

Diabetes with Renal Manifestations

Examples of clear documentation:

- "CKD stage 4 due to DM 2, uncontrolled"
- "Type 1 controlled Diabetic CKD stage 5, on long term dialysis 3x wk with Dr. Smith, no problems at this time"

Diabetes with Ophthalmic Manifestation

Diabetic patients should have diabetic eye exams annually.

Examples of clear documentation:

- Blindness due to DM 1, controlled.
- Type 1 uncontrolled diabetic proliferative retinopathy.

Diabetes with Neurological Manifestations

Examples of clear documentation:

- Polyneuropathy and gastroparesis due to DM 2, uncontrolled
- Type 1 controlled diabetic peripheral autonomic neuropathy
- Type 2 uncontrolled diabetic peripheral neuropathy

Diabetes with Peripheral Circulatory Disorders

Examples of clear documentation:

- PAD lower exts. due to DM 2, controlled.
- Gangrene lt great toe due to controlled Diabetic PVD.

CHARTING SPECIFICS AND EXAMPLES

CARDIOLOGY

Often Old MI and Angina co-exist. Evaluate and document all cardiac conditions, and any treatment patient is receiving.

CHRONIC CONDITIONS

All chronic conditions must be fully assessed annually. Examples of terms that indicate evaluation and treatment:

- Stable on meds.
- Conditions worsening- medication adjusted (include name of medication and changes made or changes to treatment plan).
- Tests ordered-documentation reviewed and results entered into treatment plan.
- Condition improving.

CIRCULATORY

Acute CVA- Rarely treated in an office setting. Most cases are treated in ER or inpatient setting and followed up with PCP. Documentation that states "history of" CVA for follow up treatment is clearer, as it is no longer an acute event.

CVA Late Effects- Document any late effect due to CVA, "Hemiparesis" should not be documented only as "R/L sided weakness". Dominant or non-dominant sides are additional important qualifiers to note. Example:

- Dominant right-sided hemiparesis, due to CVA in 2006, stable with no improvement.

Vascular Disease of Aorta vs Aortic Valve- Atherosclerosis of aorta must clearly distinguish vessel from the valve--using "aorta" or location to indicate the vessel. Examples:

- Ascending aortic atherosclerosis
- Atherosclerosis of aortic arch
- Aortic valve stenosis
- Abdominal aortic atherosclerosis

Do not document "Venous insufficiency" if you mean PVD or PAD.

FRACTURES

Document Pathological Fractures as current, acute or chronic as long as there is active treatment documented as well. Document cause as well.

HISTORY OF

Do not use **"History of"** if patient is still receiving treatment and condition is not resolved.

Examples of incorrect usage:

- History of Diabetes- Type II, diet controlled.

LABS

Do not code a lab test result without connecting it to a diagnosis. Simply referring to an abnormal blood sugar without noting the patient is a diabetic cannot be coded as diabetes.

MENTAL DISORDERS

Major Depression- Clearly document "Major Depression" or "Major Depressive Disorder" (MDD) if that is what is wrong with the patient. Examples:

- Major depression- Stable on Med.(include name) Patient able to do daily tasks, sees Dr. Smith for treatment. You must note severity as well.

NEOPLASMS

Becomes **"History of"** if it has been treated by surgery, radiation or chemotherapy and there is no current indication of disease.

- Patients who have not received treatment for their malignancy should continue to be documented as current and not history of.
- Breast and prostate cancer patients receiving long term adjunct therapy can be documented with a current malignancy, as long as treatment is documented and active.

Metastatic Disease- Document all metastatic diseases and site along with primary site, and current treatment. Examples:

- Mets to bone, multiple sites, due to prostate CA, patient is on chemotherapy.
- Stage IV lung CA with mets to brain, patient is on chemotherapy.

NEUROPATHY

Assess and document current treatment for chronic neuropathy conditions:

- Multiple Sclerosis
- Alzheimer's Disease
- Huntington's Disease
- Myasthenia Gravis
- Inflammation and Toxic Neuropathies
- Epilepsy

NUTRITION

ICD-10 requires a BMI of 40 or above when diagnosing and documenting for Morbid Obesity. This may differ from other standards.

Malnutrition- Evaluate and document for BMI less than 20.

PULMONARY

Acute Respiratory Failure- Rarely treated in an office setting. Treated in ER or inpatient setting and followed up with PCP. Document "history of" or "chronic" respiratory failure as appropriate.

COPD- Document current treatment, medication, response to treatment and any related PFT or CT results. Document tobacco exposure. Example:

- Moderate COPD- Compensated on Albuterol, PFT done 05/12/14, shows mod. obstruction. 40+ pack year smoking hx. Pt continues to smoke.

RENAL DISEASE

Chronic Kidney Disease- Document stages of CKD along with evaluation and treatment. Calculated eGFR from labs are recommended to establish CKD stages. Example:

- CKD stage 4, GFR 20, will refer to nephrologist for evaluation.

Dialysis Status- Document if patient is on long term dialysis also, frequency, who they are seeing for treatment and any complications. Example:

- CKD stage V, currently on dialysis with Dr. Smith, 3x wk, no problems today.

SKIN

Ulcers- Do not document skin ulcers as "open wound" or "chronic wound" This will not allow coder to assign the correct code for skin ulcer. Examples:

- Diabetes type 1, uncontrolled with rt ankle ulcer, little improvement, will continue dressing changes 3xwk
- Pressure ulcer lower back, stage 3, improving, continue packing 3xwk. S/p back surgery.

STATUS AND CO-EXISTING CONDITONS

Many of these conditions get left off the medical record: Document, at least, annually.

- Ostomies
- Quadriplegia
- Paraplegia
- Amputations
- Alcoholism in remission
- Organ transplants
- Dialysis status
- Drug dependence
- AIDS or HIV

Charting Tips

Document explicitly for all conditions being addressed. Documentation must be complete now more than ever with ICD-10 implementation.

Do not list diagnoses in the assessment without some sort of treatment or status documented to show that you have addressed each condition on that visit.

Make sure all codes reported on encounter forms or superbills match what's charted for that date of service.

Do not write the diagnosis code in place of the narrative diagnosis. This is not acceptable because all coding must be done from a narrative to ensure the correct code is assigned.

Do not use symbols to indicate a disease. Examples: ↑BP or ↑lipids. These are not the same as hypertension or hyperlipidemia and are coded differently.

If it isn't documented, it didn't happen!

Medical Record Criteria

- Use only standard medical abbreviations
- Ensure the medical record is legible and complete.
- Patient's name and date of service must be on each page of the record.
- Use SOAP note format when applicable.
- Each record must have clear clinician signature with a credential after the name.
- Stamped signatures are not accepted.
- Electronic signatures must be stated as "Authenticated by" "Signed by" or "Approved by" and include the date, name and credentials of the authoring provider.
- Amendments to records must be made as close to the date of service as possible, generally within 72 hours. It is not acceptable to create an amendment months or years after a service.
- Late entries should be clearly labeled as such with:
    - Date and time of late entry
    - Reason for late entry
    - They should be done relatively close to the time of service.
- Corrections should be done by a single strike through to the error. No portion of the medical record should ever be obliterated.

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Physician Guide to Documentation

Documentation tips based on the Official ICD-10 Guidelines for Coding and Reporting and CMS Guidelines for Medicare Advantage Plans

For more information on Documentation and Coding go to:

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