Coding Accuracy and Why it Matters

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MY CODING HISTORY

- I have been diagnosis coding for ***31 years***
  - Workers' Compensation Managed Care for ***19 years***
  - Risk Adjustment with Paramount/Medical Mutual for ***13 years***
- Participated in ***SEVERAL*** CMS/HHS Audits
  - ***3*** Contract Risk Adjustment Data Validation (RADV) audits
  - **8** National RADV/Part C Improper Payment Measure audits
  - ***10*** HHS-RADV (ACA) audits

OBJECTIVES

- Understand the importance of coding accuracy and specificity under ICD-10-CM and why it is required—not optional
- Explain how accurate diagnosis coding impacts risk adjustment, reimbursement, and quality outcomes
- Recognize the role of documentation in supporting accurate, complete, and defensible coding
- Identify common coding errors and documentation omissions that lead to compliance and audit risk
- Apply best practices for documenting chronic conditions, manifestations, laterality, staging, and status
- Understand the shared responsibility between providers and coders in achieving coding accuracy
- Describe how accurate coding supports patient care, data integrity, and population health management

AGENDA

- Coding Specificity
- Why it Matters in Risk Adjustment
- Effective Documentation Recommendations
- Common Coding Errors and Omissions
- Key Take Aways

Coding Specificity

ICD-10-CM at It’s Finest

Coding Specificity and ICD-10-CM

- ICD-10 code set introduced us to coding at a higher level which included higher level of *CODING SPECIFICITY*
  - Over 50,000 MORE codes than ICD-9
  - MORE digits that allow better details regarding a ***disease***, ***severity***, and ***precise anatomic site*** including laterality
- CMS issues ***ANNUAL*** Official Coding Guidelines (OCG)
- American Hospital Association (AHA) issues QUARTERLY Coding Clinics

Coding Specificity Because …

- The Official Coding Guidelines* (OCG) say so
  - ***Section I.B.2*** - Diagnosis codes are to be used and reported at their ***highest number of characters available*** and to the ***highest level of specificity*** documented in the medical record.
  - ***Section I.B.9*** - When the combination code lacks ***necessary specificity*** in describing the manifestation or complication, an additional code should be used as a secondary code.
  - ***Section IV.F.1*** - Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide ***greater specificity***.
  - ***Section IV.F.3*** – **Code to the highest level of specificity** when **supported by the medical record documentation**.

*ICD-10-CM Guidelines FY26 October 1, 2025

Coding Specificity Because ...

- **Improves patient care**
  - Accurate patient health status
  - Continuity of care
  - Quality of care
- **Important to data research**
  - Health Registries
  - Healthcare quality improvement
  - Population health management
  - Identify trends or patterns in patient care outcomes
- **Ensures accurate billing and reimbursement**

Risk Adjustment and Coding Accuracy

HIGH LEVEL ~ What is Risk Adjustment

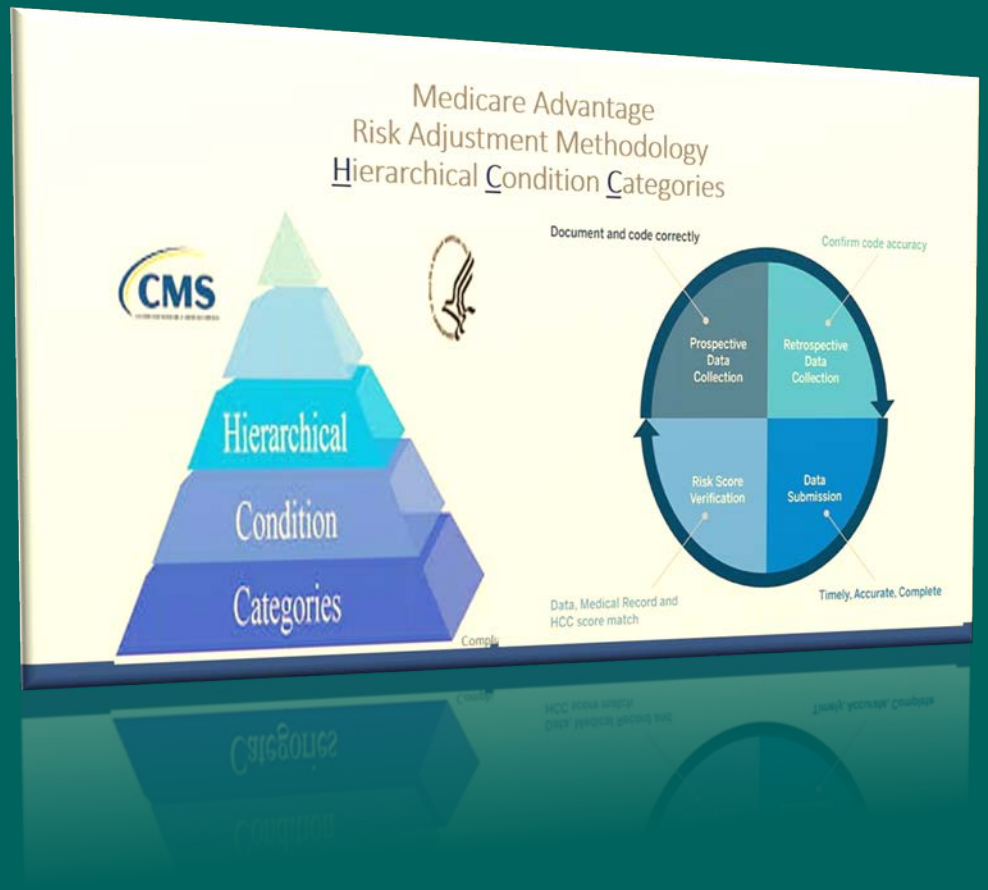
- Patient diagnoses (from claims or medical records) are collected
- Diagnoses are grouped into risk categories (e.g., diabetes, CHF, COPD)
- Each category has a weight based on expected cost
- All weights are added to create a risk score
  - 1.0 = average expected cost
  - >1.0 = higher-than-average expected cost
  - <1.0 = lower-than-average expected cost

CMS HCC Model

- CMS uses the Hierarchical Condition Category (HCC) model
  - Currently this is the V28 model
- Payments are ***adjusted*** based on
  - Demographics (age, sex, disability status)
  - Diagnosed conditions (typically reported annually and in most cases chronic)
    - Patient with diabetes + CHF = higher risk score
    - Health plan receives higher payment to cover expected costs
    - This encourages plans to manage chronic conditions effectively

Where Risk Adjustment is Used

- CM Medicare Advantage
- ACA Marketplace Plans
- State Medicaid Programs
- Value-based Care Payment Models



ACCURATE Coding is Critical

- Risk adjustment depends on ***accurate***, ***complete***, and ***supported diagnosis coding***
- Poor coding can lead to
  - Underpayment
  - Compliance risk
  - Inaccurate quality reporting
  - Skewed population health data
- Proper documentation, coding audits, and provider engagement are essential in risk adjustment programs
  - CMS rolled out ROBUST audit schedule
  - Office of Inspector General Work Plans include several Risk Adjustment initiatives
  - Annual ACA risk adjustment data validation audits

Effective Documentation Recommendations

DETAILS are IMPORTANT

Document, DOCUMENT, Document

- Report ***ALL diagnoses*** that impact the patient's evaluation, care, and treatment during encounter *
  - Reason for visit
  - Chronic conditions that impact medical management of acute condition
  - Treatment rendered
  - Assessment, what is **D**iagnosis, what is **S**tatus of diagnosis, and what is **P**lan of care for diagnosis
- Use only standard medical abbreviations
  - If can be used multiple ways, spell it out (EMR's helped this)
    - ARF can be acute renal failure OR acute respiratory failure

*AHA Coding Clinic Q3 2021 -Reporting of Additional Diagnoses in Outpatient Setting
*AHA Coding Clinic Q2 2022 – Hierarchical Condition Category (HCC) Coding

Some IF Statements

- Don't document "history of" a condition **IF** it currently exist
  - *Patient is here today for medication management ~~with history~~ of asthma, diabetes, and high blood pressure*
- You can code a stable condition **IF** a patient has a condition that *requires* medication to keep it stable
  - Congested heart failure stable, on Lasix
  - Diabetes, controlled, on Metformin
  - COPD, stable, on Advair
- In an outpatient setting, **IF** the clinician documents "*probable*", "*suspected*", "*questionable*", "*rule-out*", "*versus*", "*working diagnosis*", and/or "*consistent with*" in the assessment of a patient, that condition CANNOT be coded

Acceptable Medical Records

- Must include:
  - Patient name
  - Encounter date
  - Signed
- Be sure your documentation is ***clear***, ***concise***, ***consistent***, ***complete***, and ***comprehensible***
- Justify the treatment and level of care

Common Coding Errors/Omissions

Common Coding Errors

- Coding straight from the index
  - Use the notes in the ***Tabular List*** to ensure accurate selection of code
- Truncating codes
  - Check to see if condition requires 4th, 5th, 6th, or 7th digits
- Settling for a code that is vaguely appropriate
  - Only use “other and unspecified” or “other specified,” ***if you have exhausted all other possibilities***
- Coding active cancer when it should be HISTORY OF
  - ***No active treatment or evidence of disease*** warrants diagnosis of ‘history of’

More Common Coding Errors

- Coding an ACUTE condition in an outpatient office setting
  - An acute myocardial infarction (MI) is ***valid for 4 weeks (28 days) or less from onset***, then become an old MI
  - An acute cerebral infarction becomes history of or sequelae of once discharged
- Not documenting substance abuse dependency
  - Need to know if ***abuse, use, dependent, or in remission***

Not Documenting STAGE of Condition

Chronic Kidney Disease

N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.30 - N18.32	N18.3 Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
N18.9	Chronic kidney disease, unspecified

Not Documenting STAGE of Condition

Pressure Ulcers

stage 1 (healing) (pre-ulcer skin changes limited to persistent focal edema)

stage 2 (healing) (abrasion, blister, partial thickness skin loss involving epidermis and/or dermis)

stage 3 (healing) (full thickness skin loss involving damage or necrosis of subcutaneous tissue)

stage 4 (healing) (necrosis of soft tissues through to underlying muscle, tendon, or bone)

- Specify SITE as well

Not Documenting MANIFESTATIONS of a Condition

Diabetes *with*

E11.00 - E11.01	E11.0 Type 2 diabetes mellitus with hyperosmolarity
E11.10 - E11.11	E11.1 Type 2 diabetes mellitus with ketoacidosis
E11.21 - E11.29	E11.2 Type 2 diabetes mellitus with kidney complications
E11.311 - E11.39	E11.3 Type 2 diabetes mellitus with ophthalmic complications
E11.40 - E11.49	E11.4 Type 2 diabetes mellitus with neurological complications
E11.51 - E11.59	E11.5 Type 2 diabetes mellitus with circulatory complications
E11.610 - E11.69	E11.6 Type 2 diabetes mellitus with other specified complications
E11.8	Type 2 diabetes mellitus with unspecified complications
E11.9	Type 2 diabetes mellitus without complications

Not Documenting MANIFESTATIONS of a Condition

Hypertension *with*

I10	Essential (primary) hypertension
I11.0 - I11.9	I11 Hypertensive heart disease
I12.0 - I12.9	I12 Hypertensive chronic kidney disease
I13.0 - I13.2	I13 Hypertensive heart and chronic kidney disease

OMISSIONS

- These common omissions could be documented in '*Physical Exam*' portion of medical record and carried into ASSESSMENT for specificity
  - **Laterality**
    - Important in some specialties to know right, left, or bilateral
  - **Artificial openings**
    - Need status of ostomy
  - **Amputations**
    - Absence of limb

Engaging Providers to Promote Coding Accuracy

- Onboarding and continuous training
- Focused on patient care
  - Document chronic conditions at least annually
- Auditing medical records and sharing feedback

Key Takeaways

- Coding specificity **is required**, not recommended
- A joint effort between the healthcare provider and the coder is ***essential*** to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures
- Accurate and ***COMPLETE*** coding documentation ensures quality healthcare and delivery, effective communication between clinicians, and accurate reimbursement

QUESTIONS

Thank You

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