How we can help you…

Optimize documentation capture by providing education to our clinicians on multiple aspects.

Examples:

- ✓ Elements of a Level of Service (E&M)
  - HPI, Exam, MDM, Time
- ✓ Preventive and other Patient
  - Management Services
- ✓ Wellness, Advance Care Planning
- ✓ Documenting Acuity (ICD-10)
  - Complications, Due to
- ✓ HCCs (Hierarchical Condition Categories)
  - Type 2 DM with Hyperglycemia
  - Current Insulin Use
  - S/P LLE Amputation, below the knee
- ✓ Surgical and Procedure Notes
  - Required Elements
  - Supporting Medical Necessity
- ✓ Attestations
  - Surgical
  - E/M
    - Resident
    - Split/Shared
    - Incident-To

- ✓ And More…

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Cooper University Health Care

Clinical Documentation Improvement - Ambulatory

TIP Sheet #1:
Updating the Problem List
"Uncontrolled T2DM"
& M.E.A.T.

Cooper
One Team. One Purpose.

To Serve, to Heal, to Educate

How "Uncontrolled" T2DM = E11.9…?

The Issue: ICD-9 diagnosis verbiage allowed for "uncontrolled diabetes," which was indicated with the last character in the code: 250.0***2***.
ICD-10 does not allow for "uncontrolled" DM without further specificity as to Hyperglycemic (aka "poorly controlled DM") or DM with Hypoglycemia.
The *verbiage* in your documentation – not the codes selected –now drives the final diagnosis selection. Not updating the problem list will likely cause the unspecified T2DM diagnosis code to be utilized.

The Fix: Update patients' Problem Lists. From the EPIC diagnosis logic tree, make the appropriate sub-selections using verbiage "Type 2 diabetes."
If you use this verbiage/diagnosis code(s) frequently, save the diagnosis information as a favorite. Using your newly updated specific diagnosis information, simply link it into your Progress Note encounter.

The Results: When reported appropriately, the more accurate diagnoses & heavily weighted HCCs will be submitted to the carriers.

Ensure your HCCs make the M. E. A. T.

The Issue: HCC diagnoses found in the Assessment and Plan section of your note are not documented or described elsewhere in the encounter. Simply pulling an HCC into your A&P does not "MEAT" medical necessity for coding purposes:

M – Monitoring (s/s, disease progression, disease regression)
E – Evaluating (test results, medication effectiveness, response to treatment)
A – Assessing/Addressing (ordering tests, discussions, record review, counseling)
T – Treating (medications, therapies, other modalities)

The Fix: For conditions primarily followed and treated by another physician, it is still okay to document minimally and pull the diagnosis information into your A&P. For example: "Mr Smith is following Dr Jones at MidAtlantic Retinal for his proliferative diabetic retinopathy." Although you are not the primary clinician, you have ***addressed*** and documented his proliferative diabetic retinopathy.

Pete and Repeat… Can we learn from the jokes?

Actually, we can…

And the payment methodologies in place today demand that we do. Every year, the HCC diagnoses slates are wiped clean at the carrier for every affected patient.
What does this mean?
The clean slate compels clinicians to annually re-document their patient's chronic and acute conditions. While an acquired absence of a limb is not going to grow back, documentation of these and other chronic or acute conditions also affords us the opportunity to add acuity and specificity to our patient's diagnoses. In doing so we can better project Risk Adjustment for future resource allocations, thereby providing complete and better patient care for our patients' anticipated needs.