



NAMAS Weekly Auditing & Compliance Tips

May 13, 2016

Using The Right Diagnosis

One of the hardest parts when reviewing a medical record for coding or auditing is the determination of what conditions were addressed. Any condition that is taken into account or affects patient care, treatment or management should be documented and ultimately coded. However, the documentation still needs to support that the provider did in fact review, consider, or treat a condition in order for it to be supported. And whether it is supported affects more than just what ICD-10 code ends up on the claim. Showing the additional work affects the overall medical necessity of the visit, the level of medical decision making, and ultimately, the level of service that is supported. In addition, as many hospitals and clinics are becoming accountable care organizations, the right diagnosis becomes paramount in receiving appropriate reimbursement for the care of the patient.

Making the right diagnosis selection relies on using proper documentation that supports the most accurate representation of the condition. Many coders and healthcare workers will be quick to mention the giant gap in what is clinically significant and how it translates into coding.

To assist in closing the gap, consider the following points.

When choosing your diagnosis code:

- The condition must be clearly documented in your assessment with a plan of care addressing it.
- Document and code for all problems assessed during the encounter, not just the primary reason for the visit.

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NAMAS is proud to be the leading source of continued education and training for medical auditors and other healthcare professionals.

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NAMAS 1 Day E/M Auditing Boot Camp

- If it is not addressed, it should not be coded. If there is nothing in the history, exam, or plan of care associated with the condition it is not supported as being addressed.
- When a condition impacts the management of an unrelated diagnosis, the impact should be clearly documented.



Resolved problems or past history:

- From a coding perspective, the statement 'history of' means the patient no longer has the problem, and is no longer receiving treatment for that condition.
- If the condition is still receiving active treatment, it should not be documented as 'history of'.
- If a personal history of a resolved condition or a family history of a condition is relevant to the present concerns, then it is documented and coded as 'history of'.

Documenting undiagnosed conditions:

- Code for conditions described as 'probable', 'rule-out', 'consistent with' or any term that indicates any level of uncertainty is not supported for professional services. Instead, the sign or symptom should be coded. Facilities may choose to code for these as it shows the medical necessity of utilizing additional supplies.
- Document to the greatest degree of certainty for each diagnosis.

Diagnoses with cause/effect relationship or manifestations:

- When documentation mentions the conditions but without a stated causal relationship, each condition is coded separately. There is no assumed connection between the presence of a disease and another condition.
- The exception to the causal relationship guideline is for when hypertension and chronic kidney disease are both present, it is assumed to be hypertensive chronic kidney disease which is coded with I12._ versus I10. If the documentation clearly states that the hypertension and chronic kidney disease are not related, then it may be coded separately.
- In order to code a disease or condition as a manifestation of the disease, the causal relationship must be noted. For example: diabetic nephropathy, hypertensive heart disease or retinopathy due to diabetes.

Making the right diagnosis selection with proper documentation will support the more complex level of medical decision making, and will allow the provider to

Whether you're new to E/M auditing, or are an experienced auditor, this course will leave you with a new perspective on E/M auditing. Our experienced instructors will dig into the details of E/M auditing, covering topics like: medical decision making, medical necessity, 1995/1997 guidelines, the grey areas of audit policies, and more!

Earn 8 AAPC CEUs for attending this course. Your registration also includes your curriculum manual, NAMAS audit grid, and a 1 year NAMAS membership!

Upcoming Classes:

May 19, 2016: Ft. Lauderdale, FL

June 7, 2016: Saratoga, NY

June 17, 2016: Orlando, FL

June 21, 2016: Albuquerque, NM

June 28, 2016: Dallas, TX
Please call or email NAMAS to register for this session

July 7, 2016: Charlotte, NC

July 12, 2016: Detroit, MI

New! Live Online Session beginning August 9th!

Additional dates and cities scheduled; click the image above for full schedule

Current NAMAS members save \$100 on Boot Camp registration!

accurately capture the value of the work they performed.

**This Week's Audit Tip Provided by:
Omega Renne, CPC, CPCO, CPMA,
CEMC, CIMC**

Omega is a Senior Auditing Specialist for our parent organization, DoctorsManagement LLC



Sources:

- *The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), (2011, October). ICD-9-CM official guidelines for coding and reporting. Retrieved October 20, 2011, from Department of Health and Human Services (DHHS) Web site: http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf*
- *ICD-10 Coding Guidelines*

Click here for details

Weekly Tip Sponsor

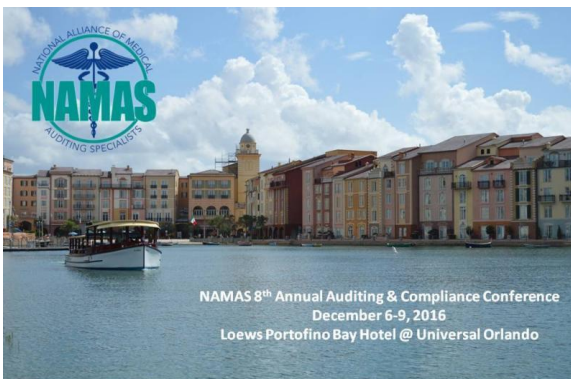


NAMAS Calendar of Events



Click the image above to view our monthly calendar

NAMAS 8th Annual Auditing & Compliance Conference



Pre-Conference:

Dec 6 2016

Conference:

December 7-9 2016

Location:

Loews Portofino Bay Hotel
Orlando, FL

**Click Here to View the
Conference Agenda**

New for 2016!

Attendees can choose between FOUR Pre-Conference tracks: General Auditing, E/M Auditing with Precision Testing, Physician-Based Compliance and Facility-Based Auditing presented by Panacea Healthcare Solutions. Agenda for the facility-

Upcoming Webinars

NAMAS is proud to present the following webinars in May

WEBINAR



E/M Encounter Review

Speaker: Aimee Wilcox
Tuesday, May 17
2pm EST

Mitigating Your Practices' Risk

Speaker: Frank Cohen
2pm EST

NAMAS Members: Watch your

based auditing track will be released soon

Limited Time Offer! Ends 4/30/16

Register for conference and receive registration to our pre-conference for FREE!

Reserve your spot at conference with just a \$50 deposit!

Click here to reserve your conference registration

Email for Registration Links

Non-Members: Email namas@namas.co to learn how to attend these webinars

A Note from PowerBuying



Did you know that document destruction is an area where the PowerBuying Program can help your practice save money? We can help cut your cost on your monthly contracted amount and/or set you up with additional disposal bins for the same or lower cost!

To start saving, contact Craig King today at 800-635-4040 or email cking@drsmgmt.com

A Note From Our Sponsor



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We assist in the following services for healthcare providers: revenue recovery, appeals, receivables followup, compliance and collection services.

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Our weekly auditing & compliance tip emails are available to anyone who could benefit from this information.

If you know someone who would like to receive these emails, invite them to sign.

Click the image above to be added to our email list!

A Note From Our Parent Organization: DoctorsManagement, LLC

Practice Assessment

D O C T O R S[®]
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**Now Available!
NAMAS Electronic
Audit Grid**

Is it time for your practice to have a checkup? A DoctorsManagement Practice Assessment is the equivalent of a complete history and exam physical performed on your practice.

Click the image above to learn more and request your Practice Assessment

The image shows a screenshot of the 'EIM Documentation Auditor's Worksheet'. At the top, there are fields for 'Auditor', 'Medical Code', and 'Clinic'. Below these are radio buttons for 'New Office', 'New Hospital', 'Established Office', 'Subsequent Hospital', and 'Consult'. A 'Save This Form with a New Name' button is also present. The main body of the form is a large grid with columns for 'History', 'Physical', 'Diagnosis', and 'Treatment'. Each cell in the grid contains a list of medical services and modifiers with checkboxes for documentation. At the bottom, there are sections for 'Documentation Checklist' and 'Summary'.

Our ALL-NEW electronic audit grid automatically calculates the documented level of service as you enter the individual components of the encounter.

This easy to use, helpful auditing resource is now available for purchase in the NAMAS Online store. Click the image above to purchase or to read more information.

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