Priority Health

Reporting diagnosis codes

To capture the full disease burden of a patient's conditions, follow the documentation guidelines below, as applicable.

Two pronged goals in diagnosis-based risk adjustment:

1. To ensure that patients' conditions are sufficiently diagnosed, documented, coded to measure and monitor outcomes.
2. To accurately track the care needed through current and potential resources and reimburse accordingly.

Do document:
Diagnosis

- To the highest level of specificity
- Accurately
- Making sure its clinically valid and supported

Example: Malignant neoplasm of breast cancer code risk adjusts but the history of breast cancer code doesn't. Any malignancy undergoing active treatment should be coded with the malignant neoplasm code.

Download our Diagnosis coding tip sheet for helpful information on cancer documentation.

*The personal history code is applied **only** if the malignancy is not present.*

If the patient is diagnosed with breast cancer and is currently receiving any active treatment including adjuvant treatment for cancer, then code as an active diagnosis.

If the cancer is in remission, code cancer as in remission.

If the cancer is not in remission, code personal history of cancer.

If the patient is on therapy for prophylaxis, code personal history of cancer.

Do document:
All co-existing conditions affecting patient care with supporting documentation during the encounter.

Do code:
Signs and symptoms as opposed to diagnosis when a confirmed diagnosis has not been determined by the provider.

Do code:
Chronic diseases as many times as the patient receives care and treatment.

Do only use:
Unspecified codes when the medical record is insufficient to assign a more specific code.

Do link:
Current prescription medication used to the condition for which it was prescribed.

Don't code:
Conditions in the outpatient setting documented as:

- Probable
- Suspected
- Likely
- Questionable
- Possible
- Still to be ruled out
- Compatible with
- Consistent with

Do report:
Conditions at least once during the risk adjustment annual reporting period.

Examples of ongoing co-existing conditions:

- Diabetes
- Congestive heart failure
- Multiple sclerosis
- Rheumatoid arthritis

Conventions for ICD-10-CM

- The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the alphabetical index (either under a main term or subterm), or an instructional note in the Tabular list.
  - These conditions presume a causal relationship without a provider having to explicitly link them. If these relational terms aren’t used, then the provider must link the conditions.
    - *Example: Hypertension with chronic kidney disease*
- The “see” instruction following a main term in the alphabetic Index indicated that another term should be referenced.
- The “see also’ instruction following a main term in the alphabetic index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful.
- A “code also” note instructs that two codes may be required to fully describe a condition, but this note doesn’t provide sequencing direction. The sequencing depends on the circumstances of the encounter.

Reference:

1. Crc, P. S. B. C. C. C. (2020). Risk Adjustment Documentation & Coding, 2nd Edition. In Common Administrative Errors and Processes. (2nd ed., pp. 3-5). American Medical Association Press.