

ICD-10: THE 10 COMMANDMENTS OF CODING

1. The Documentation Must be Legible - If a record cannot be read or interpreted, it is of little value. However, with a little help, the coder or auditor should be able to handily decipher the provider's documentation. Dictated or computer generated records can be a great benefit in this area.

2. Every Record Must Contain Basic Data - These include patient name, patient birth date, the encounter date and time, vital signs, allergies and the location of the service. Upon completion, every record must be signed by the provider, whose printed name should also be a part of the record.

3. The Record Must Be Organized - Encounters should follow the format of: chief complaint, history, exam and diagnosis/plan. The history (HPI) must be broken down into the review of systems (ROS) and the past, family and social history (PFSH).

4. Documentation Must Match the Billed Services - Every billed service and its corresponding diagnosis code must be clearly documented in the medical record. For example, if the provider is relying upon the evaluation of two stable medical problems to support a level 4 encounter, the pertinent history and exam for each of the problems must be found in the record.

5. Medical Decision Making (MDM) Must Match Service Level - MDM is the overriding determinant of the level of service and a billed service level should never exceed the MDM reflected in the documentation.

6. Addendums or Alterations Must Be Properly Identified - Ideally, an encounter should be fully and completely documented within eight hours, and certainly no more than 24 hours after the service. Additions to a completed record should be clearly labeled as such and include the date, time and reason for the addendum. When making a late addendum, it is preferable to place it on a separate page from the original document to avoid the impression that the author was attempting to alter the original record.



7. Do Not Clone Medical Records - Cloning medical records refers to the abusive use of boilerplate data, or carrying forward large portions of a patient's prior record to the current encounter.

8. Do Not Abuse Modifier 25 - Modifier 25 is proper only when a separately identifiable E/M service is performed, in addition to another procedure or service.

9. The Necessity of Ancillary Testing Must Be Clear - When testing or procedures are part of the encounter, the reason and necessity for these items must be clearly documented or intuitively obvious to medical personnel. Although "rule out" diagnoses are not valid to submit for billing purposes, they can be used in the text of the record to explain the need for testing.

10. Note Face-to-Face Time for Time-Based Encounters - When time-based billing is used, a simple statement that over 50 percent of time was spent in consultation with the patient is required, as well as the total number of minutes spent "face-to-face" with the patient. The subject matter of the counseling should also be recorded in adequate detail to support the amount of counseling time.

Source: AAPC Physician Services | posted by Stephen C. Spain, MD, FAAFP, CPC

