Quality Coding

Providers must adhere to the following standards for quality coding:

1. **Ensure coding is consistent with and supported by medical records.**
   To be eligible for reimbursement, a service must be properly documented in the medical records. If a claim includes codes that are not supported by the medical records, those lines may be denied. Members may not be billed for services that are denied as not documented in the medical record. (For more information about medical record documentation requirements, refer to Section 13.)

   Code the diagnosis related to the encounter in the primary position on the claim or according to specific ICD-10 clinical modification guidelines. For claims subject to Medicare Severity Diagnosis Related Groups (MS-DRGs) reimbursement, a different MS-DRG may be assigned.

2. **Be specific.**
   - Code the condition to the highest degree of certainty according to the current ICD system.
   - Always include “history of” coding for patients who no longer have an active condition (e.g., cancer, stroke, acute MI, acute diabetes). “History of” coding applies when the patient has not been recently diagnosed, is not on or deciding on treatment, is not watchfully waiting without treatment, or has declined treatment.

3. **Be thorough.**
   - Code *all* diagnoses (at least once a year) that still apply to the patient’s health status, evaluation, care, and treatment.

4. **Be consistent and persistent.**
   - Report all chronic conditions consistently for each visit.

SAMPLE of quality coding
Comparison of average and high-quality coding for a patient visit:

CONDITION DESCRIPTION	ICD-10 CODE
Scenario 1: Average coding	
Acute ischemic heart disease, unspecified	I24.9
UTI	N39.0
Scenario 2: High-quality coding	
ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery	I21.21
UTI	N39.0
Type 2 diabetes mellitus w hyperglycemia	E11.65
Manic episode without psychotic symptoms-mild	F30.11