**Past medical history**
(It’s not what you think it is)

When documenting past medical history for hospital admission, physicals or progress notes, providers typically include both resolved and current conditions that have been treated. From a coding perspective, the past medical history should only include resolved or “cured” diseases. Active or current medical conditions should not be included in this section. Examples of “cured” conditions would be infectious processes like pneumonia that has been treated and is no longer active. Conditions like congestive heart failure that may be stable but still active should not be included.

**All active conditions need treatment plans**

Any active disease should be documented with a corresponding treatment plan even if the disease is stable, the disease is being followed by another provider, or if you are only monitoring the disease at this time. An example may be coronary artery disease.

**Document active conditions yearly**

Any active medical condition needs to be documented yearly, otherwise it is considered “resolved.” It is important to make sure the documentation makes sense.

**Avoid using generic codes**

Generic codes may not accurately reflect a patient’s condition. One example is congestive heart failure. Most health care providers use the generic code I50.9 for heart failure, however specific codes exist for:

- Acute systolic heart failure - I50.21
- Chronic systolic heart failure - I50.22
- Acute diastolic heart failure - I50.31
- Chronic diastolic heart failure - I50.32
- Acute on chronic combined systolic and diastolic congestive heart failure - I50.43
- Left sided heart failure - I50.1

The signs and symptoms of various forms of heart failure can be different. Generic codes may not describe the patient and how the disease is affecting their health.

**Linking diseases**

If a cause and effect relationship exists between diseases, then the provider needs to establish this “link.” A clinical example is peripheral neuropathy, which is a manifestation of diabetes over time. Diabetes, hypertension, renal failure, congestive heart failure, and coronary artery disease are the main conditions that are associated with this cause and effect relationship. How you document the “link” is important. Words like “and” or “with” do not always infer that a “link” exists between the conditions. Descriptive terms such as “diabetic kidney disease” or precise wording such as “chronic kidney disease secondary to diabetes” should be used.

If you have properly documented the “linked” disease, you must also remember to address the manifestations themselves. For example, documented diabetes type 2 with secondary peripheral neuropathy is not enough. A provider needs to assess the peripheral neuropathy individually with a separate treatment plan.

**Multiple complications can exist**

Diabetes may cause multiple complications that are directly linked to the disease. As a provider, you need to document all existing complications. For example, diabetes may present multiple complications such as hypoglycemia, renal failure, peripheral neuropathy, and retinopathy.

**Don’t try to be a professional coder**

Clinicians should focus on accurately describing and documenting conditions. This helps the coder attribute the appropriate code to the patient. Remember, your objective is to accurately “paint the picture” of the patient’s overall health.
Cancer
(Current versus history)

The one thing we cannot tell you is when a cancer is “cured.” We define cancer as being active when the patient is receiving chemotherapy, radiation therapy, and/or seeing the provider regularly to receive treatment. Once treatment is no longer active, the cancer becomes a history of cancer though the cancer may not be 100% resolved/cured. Important: post treatment prophylaxis treatment such as Tamoxifen for breast cancer does not make the cancer active.

Cerebral Vascular Accident (CVA)
(Using the right codes at the right time)

Acute Stroke codes should only be used during the initial event and corresponding hospitalization. After the acute event, the CVA should be documented as either a CVA with its sequelae or as a history of CVA with no sequelae. Please note: residual effects can change over time as patients regain function.

Major Depressive Disorder
(Major versus mild)

Depression is broken down to mild depression and major depression. Tools like the PHQ-9 allow you to diagnose and monitor a patient’s depression in conjunction with your medical opinion. When you review the DSM-V, you will notice that once medications are prescribed for depression, patients are diagnostically classified with major depression.

When documenting depression the clinician needs to do the following:

› Document the degree of depression as being mild, major, or severe.
› Define the episode of depression as being a single or recurrent episode
› Document the status of remission as being full (more than 2 months of depressive symptom regression) or partial (1 to 2 months of symptom regression)
› Identity if there are any psychotic features associated with depression.

Substance use
(Abuse versus dependency)

Please refer to the DSM-V to review the details of substance abuse versus dependency. The one key difference between the two is that dependency implies that the patient will go through withdrawal if the substance is taken away. The easiest way to distinguish between the two is to ask yourself whether or not you would place the patient on a withdrawal protocol if they were hospitalized.

Z-Codes
(Capture changes)

Patients have “reminders” of their medical experiences. These reminders are demonstrated by physical “losses” or “gains” from their birth body, such as:

› “Loss” of a lower leg from diabetes
› “Gain” of a colostomy tube
› Foreign bodies, new holes, and “lost” parts

Z-Codes should be used regularly to represent the true picture of the patient’s past health and how that affects them today.

Malnutrition

When a patient has a 5% or greater weight loss in a short period of time, this could indicate the possibility of malnutrition. The health care provider can add lab work, such as an albumin or a pre-albumin, to the nutritional assessment – however this does not clearly confirm the diagnosis of malnutrition. Several disease states can affect this lab result, which can skew clinical judgment. Therefore, a Mini Nutritional Assessment (MNA) should be performed (http://www.mna-elderly.com/), to assist the clinician to correctly assign the diagnosis of:

› Mild protein calorie malnutrition - E44.1
› Moderate protein - calorie malnutrition (E44.0)

It is important to link the diagnosis of malnutrition to a reportable secondary diagnosis, such as dementia or malignancy. Other codes that are helpful when assessing nutritional status include:

› Adult failure to thrive - (R62.7)
› Cachexia (R64)