Correct coding requires that the immediate problem of the patient be evaluated, documented and coded. In addition, all conditions that affect the composite picture of the patient’s health status need to be recorded at least once per year.

Here are highlights of the common coding and documentation challenged during audit of charts for risk adjustment:

**Chronic Conditions**
All chronic conditions must be fully assessed annually. Examples of terms that indicate evaluation and treatment:
- Stable on meds
- Medication adjustment to improve chronic medical conditions (includes medication and changes to treatment plan).
- Tests ordered—documentation reviewed, and results entered in the treatment plan.

**Cardiology**
Often old MI and Angina co-exist. Evaluate and document all cardiac conditions, and any treatment patient is receiving. Acute MI status coding is up to 4 weeks post infarction—it then becomes “old MI status”

**Circulatory**
CVA is an acute diagnosis only to be used at time of initial onset/diagnosis. This status then becomes history of or late effects of CVA. Document any late effect due to CVA.

**Diabetes and Complications**
When documenting diabetes, it’s important to note the following:
- Type of Diabetes, Type 1 or Type 2 or secondary.
- If Secondary Diabetes, document what the cause is or primary condition along with secondary Diabetes.
- Is the Diabetes controlled or uncontrolled? Be sure to document with hyperglycemia when indicated.

**Mental Disorders**
Major Depression—Clearly document Major Depressive Disorder (MDD) with level of severity, and not unspecified status. “Major depression, single episode, moderate”.

**Pulmonary**
COPD and Asthma—Document current treatment, medication, response to treatment and any related PFT or CT Results. Document Tobacco exposure.

**Renal Disease**
Chronic Kidney Disease: Document stages of CKD along with evaluation and treatment.

Dialysis Status: Document if the patient is on long-term dialysis and or has fistula for dialysis treatment.