COFFEE & CODING

Tuesday, December 26, 2023

Common Coding and Documentation Problems You Can Avoid

In the spirit of the season, we're offering you a holiday treat this week.

Nearly 100 people signed up for our recent Zoom webinar: "Cracking the Code: Addressing Common Problem Areas in Medical Documentation & Coding for Enhanced Compliance and Reimbursement." If you weren't able to join us for the presentation by my colleagues in coding, Angela Jordan and Nancy Entwistle, you can access a recording of the webinar by clicking the link below.

Nancy and Angela covered some of the common coding and documentation mistakes we see every day—mistakes that cost providers time and money. Here are a couple of quick examples:

External Review of Records

All too often, we see documentation that seems to focus on the words "review of records" instead of "external." To receive credit from payors, documentation must demonstrate that the review involved records that truly are external: records, communications, and/or test results from an external provider or facility.

Independent Interpretation

In a related issue, another common documentation mistake involves confusing a review of a report with an independent interpretation. Providers need to document very clearly that they reviewed the actual images and/or test results for a patient and not simply another provider's report on those images or results.

Want to learn how to avoid other common coding problems? Grab a mug of coffee and check out the webinar.

https://zoom.us/rec/share/hhklwkujtN-rs5-9VyoDeEAFMDTSY1kc7J8xDOoaRVHjvtShd1P5ZPCQajn7a79n.euJ0AIXZWIrYtr7T

We'll be back with another edition of Coffee & Coding on January 2. Until then, have a safe and happy New Year!

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