Documentation tips for primary care providers: documenting conditions managed by specialists

There are many diagnoses included in the Medicare risk model that aren't typically managed by primary care providers (PCPs). Instead, PCPs refer their patients to specialists for consultation and management. In many cases, specialists end up exclusively managing those conditions.

Addressing vs. managing

Although these two terms are used interchangeably by some providers, they mean different things.

Addressing a condition in the medical record refers to the documentation of any monitoring, evaluation, assessment or treatment of the condition; including referral of the patient to a specialist for care.

Managing a condition implies being directly involved in the medical decision making, work-up or treatment of the condition.

There are some common misconceptions about PCPs coding and reporting conditions managed by a specialist. A widely believed misconception among PCPs is that they shouldn't document or code any conditions they're not managing directly.

Some providers think it's against Centers for Medicare & Medicaid Services' (CMS) rules for a PCP to submit on a claim any ICD-10-CM codes for diagnoses managed exclusively by specialists. This isn't true for Medicare Advantage members. As long as the diagnosis is addressed by an approved provider during a face-to-face visit and is supported by documentation, the corresponding ICD-10-CM code can be submitted on a claim.

There's a common misconception that it's the responsibility of specialists to document and report the corresponding ICD-10 CM diagnosis codes on behalf of the PCPs. That's not the case The PCP is:

- Responsible for reporting all active conditions for each patient, since he or she affects the patient's care and well-being.
- Expected to address all active conditions in a face-to-face or audio and visual telehealth visit and document them in the patient's medical record at least once every calendar year, even if the specialist is managing the condition.

The CMS Risk Adjustment Participant Guide states, "Physicians should code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management."

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Examples

The PCP's documentation should include the diagnosis and a statement indicating that it's been managed or followed by a specialist. The PCP's documentation may also include the current status of the condition and the specialist's work-up or treatment plan, if known.

- "Exudative macular degeneration, followed by ophthalmology"
- "Dilated cardiomyopathy, stable, being managed by cardiology"
- "Breast cancer, stable on tamoxifen, follow up regularly with oncologist"
- "Follow up with nephrology for CKD stage 4 and secondary hyperparathyroidism"
- "Liver cirrhosis with esophageal varices, no recent bleeding, continue to follow with GI"
- "Recent eye exam with ophthalmology showed stable proliferative diabetic retinopathy"
- "Chronic respiratory failure, continue home 02 and follow-up with pulmonology"
- "HgbA1c remains high, will refer to endocrinologist for management of poorly controlled type 2 diabetes"
- "Leukemia, status post bone marrow transplant in remission, monitored by oncology"
- "Patient being seen by rheumatologist next month for systemic lupus erythematosus"

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