BlueCross BlueShield of North Carolina

Documentation & Coding Reference Guide: Outpatient Chart "Where to look"

This is a quick reference guide to assist with accurate, complete documentation and coding that reflects the true nature of a patient's current health status at the highest level of specificity. Per the *ICD-10-CM Official Guidelines for Coding and Reporting*, "The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved."

Use this guide to support accurate, audit-ready ICD-10 diagnosis coding in outpatient visits. Each diagnosis submitted must be supported by a **face-to-face** encounter and a **stand-alone** progress note for the **date of service**, with evidence the condition was **Monitored, Evaluated, Assessed/Addressed, or Treated (MEAT)**. Aim for documentation and coding reflecting the patient's current health status at the highest level of specificity (per ICD-10-CM guidelines).

Purpose: Documentation Accuracy & Patient Status Accuracy

Goal: Ensure the note captures the patient's **current** condition status on the date of service and includes clear MEAT support, so coded diagnoses reflect true patient status.

Documentation requirements (risk adjustment)

- **Stand-alone note:** Progress notes support the diagnosis.
- **Face-to-face:** Diagnosis supported in the progress note with an acceptable provider (not just billing/charge capture).
- **Date-specific:** The **service date** for the progress note is clearly documented.
- **MEAT:** Documentation supports the condition is being Monitored, Evaluated, Assessed/Addressed, or Treated (MEAT).
- **Condition timeline:** Include onset date (all) and resolution date (if resolved).
- **Medication linkage:** Link medications to the condition they treat (provider must document).
- **Clinical relevance:** Note how the condition impacts today's care (or why it must be considered).
- **Location:** Documentation is in the progress note (physician/facility record as applicable).

Where to document: acceptable vs unacceptable examples (outpatient chart sections)

Chart section	Acceptable (examples)	Unacceptable (examples)
Chief Complaint / Reason	"Follow-up T2DM/CKD—review labs, adjust meds." "CHF follow-up—weight/edema check; med reconciliation."	"Annual visit" with no condition support in the note. Dx appears only on the superbill/problem list (not discussed).
HPI / Interval History	"T2DM—fasting BG 140–170; A1c reviewed; diet reinforced; med	"DM" is listed with no status, data, or plan.

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	adjusted." "COPD—increase rescue inhaler use; counseled on triggers; refill + follow-up plan."	Copy-forward HPI with no updates for today.
ROS	"CHF—denies orthopnea; edema improved" (and addressed in A/P). "Depression—PHQ-9 reviewed; sleep/appetite discussed" (and plan documented).	ROS checkbox is the only support. ROS mentions symptoms, but A/P does not address the condition.
Physical Exam	"Diabetic foot exam: decreased monofilament sensation; counseling provided; plan in A/P." "HTN: BP documented; med tolerance noted; follow-up plan in A/P."	Normal exam + no MEAT elsewhere. Findings documented but not linked to a diagnosis/plan.
Assessment & Plan	Dx + status + plan (best stand-alone support): "CKD 3b—reviewed eGFR trend; avoid NSAIDs; labs ordered; follow-up 3 months." **Good / Better / Best (HTN):** Good: "HTN: continue meds." Better: "BP 120/76 today; continue meds." Best: "BP 120/76; continue lisinopril 10mg; recheck 3 months."	Dx list only (no status/plan). Plan present but diagnosis not stated/linked (e.g., meds refilled with no dx context).
Problem List / PMH	**Problem List:** "T2DM (onset 2008)—A1c 7.8; on metformin; active." **PMH:** "History of DVT (2002, resolved)—considered with anticoag plan documented in A/P."	Coding active HCCs from PL/PMH only, without MEAT in today's note. "History of…" listed but coded as active without current status/management.
Medication Management	"Continue lisinopril for HTN; BP at goal; recheck 3 months." "Refilled albuterol for asthma; reviewed use; return if use increases."	Medication list with no diagnosis linkage. "Meds refilled" with no condition/status documented.
Labs / Imaging	"A1c 8.4 reviewed; discussed adherence; med adjusted; repeat in 3 months." "eGFR downtrending reviewed; CKD stage documented; labs ordered."	Results copied and pasted with no interpretation/plan. Imaging report filed with no provider assessment.
Orders / Referrals	"Order microalbumin for diabetes monitoring; follow-up planned." "Referral to nephrology for CKD management; reason documented."	Orders placed but diagnosis not documented. "Follow up PRN" only.
Signature / Date	Signed/dated note with rendering provider identified. Credentials present; date/time	Unsigned/undated note. Signature missing/invalid (draft note not finalized).

	captured.	

Tip: Update the Problem List and PMH at least twice a year to keep active vs history vs resolved conditions clear.

References:

- Optum EncoderPro.com for Payers (encoderprofp.com)
- ICD-10-CM Official Guidelines for Coding and Reporting (PDF)
- ICD-10-CM Official Guidelines for Coding and Reporting, FY 2026, Section I.C.21.4 (History [of]). CMS.
- https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment
- https://www.aapc.com/blog/93841-bridge-the-documentation-gap-in-risk-adjustment/

For questions, please email the Blue Cross and Blue Shield of North Carolina Provider Engagement Risk Team at BCBSNCRiskAdj@bcbsnc.com.