Dispelling Misconceptions about VBC and Documentation

Misconceptions		Realities	
x	If I document a condition, I'm responsible for providing care for the condition	✓	Documenting a condition outside of your specialty does not make you responsible, instead those codes provide context for the care you're providing and for payers to understand clinical complexity
x	Documenting conditions outside of my specialty is 'upcoding,' or intentionally inflating reimbursement amounts	✓	If documentation and coding accurately reflects the patients' condition, coding all conditions is expected by payers and CMS
x	Capturing condition codes outside of my specialty could lead to payer audits	✓	Proper documentation of the full spectrum of patient conditions through ICD-10 / HCC coding can justify billing level 3-5 services and could reduce the possibility of audits
x	Documenting patient complexity at presentation only benefits the payer	✓	Once payers recognize the clinical complexity and risk related to each beneficiary, new contracts could allow for greater reimbursement for more complex patients or the possibility for taking on upside risk arrangements
x	Documenting and coding from last year carries over to this year	✓	Chronic conditions must be re-coded every year to capture disease severity