

Best documentation practices for diagnosis coding

The “Evaluation and Management Services Guide” issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

“Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient’s health history. Medical record documentation helps physicians and other healthcare professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s healthcare over time.”

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity facilitates:

- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely healthcare provider payment for furnished services

Key points

Legibility

The entire medical record must be legible. Remember this basic rule: If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services performed.

Patient demographics

Each page of the medical record should include, at a minimum, the date of service and the patient’s name and date of birth. Also include the patient identification number, if applicable.

Page numbering

Each page for each date of service should be numbered.

Best practice

- Page 1 of 3
- Page 2 of 3
- Page 3 of 3

If pages are numbered in this way, it will be clear to an objective reviewer whether the record for a particular date is complete. If the printed pages are inadvertently separated, page numbers would allow the medical record to be reassembled in proper order.

Healthcare provider signature and credentials

Only authorized personnel may document in the medical record, and each person must be clearly identified with full name and credentials.

- All entries must be signed and dated in a timely manner by the healthcare provider who performed the service.
- Signatures should be identified by a printed, legible name and credentials.
- Signature stamps are not accepted by CMS.
- Electronic signatures must be authenticated by the healthcare provider. For a signature to be valid, the following criteria must be met:
 - Services provided/ordered/certified must be authenticated by the persons responsible for the patient’s care.
 - Signatures are to be handwritten or electronic (stamped signatures are not acceptable).
 - Signatures should be legible.

Reference: CMS Medicare Program Integrity Manual (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4

Abbreviations and acronyms

- Limit the use of abbreviations and acronyms, or avoid them altogether.
- Use only industry-standard abbreviations and acronyms.
- Keep in mind some standard abbreviations and acronyms have multiple meanings. The meaning of the abbreviation or acronym often can be determined based on context, but this is not always true.

Best practice

- *The initial notation of a diagnosis should be spelled out in full with the abbreviation in parentheses, such as “myocardial infarction (MI)” or “rheumatoid arthritis (RA).”*
- *Subsequent mention of the condition can be made using the abbreviation.*
- *The diagnosis should again be spelled out in full in the final impression or plan.*

Dates and timelines

Specific dates and timelines provide important information and can affect diagnosis code assignment (see second bullet below regarding myocardial infarction).

- Post-hospitalization or post-operative follow-up office visits:

Vague: “Patient is here for hospital follow-up.”

Specific: “Patient was discharged from the hospital on 1/15/20xx after admission for ____.”

Vague: “Post-op visit for recent splenectomy.”

Specific: “Patient is here for first post-op visit after splenectomy performed on 3/25/20xx.”

- “Recent” myocardial infarction (MI) is a vague description that does not specify whether the patient experienced an acute myocardial infarction within the last four weeks (coded as acute MI) versus a myocardial infarction that is older than four weeks with no current symptoms (coded as historical MI).

Vague: “Follow-up office visit for recent myocardial infarction.”

Specific: “Patient was discharged from ABC Medical Center on 2/25/20xx after inpatient admission for acute myocardial infarction.”

Historical versus current

- Do not use the descriptor “history of” to describe a current or chronic condition that is still present, active or ongoing. In diagnosis coding, “history of” means conditions occurred in the past and is no longer a current problem.
- Do not use the descriptor “history of” to describe a current condition that is in remission. Describe the condition as “in remission.”
- Do not document a condition as current if it is historical only.

Consider this example: A patient with a history of prostate cancer that has been eradicated in the past presents to the office for an evaluation, examination and 6-month follow-up PSA (prostate-specific antigen) lab test to monitor for cancer recurrence.

- The assessment section should not state “prostate cancer,” but rather “history of prostate cancer.”
- The related plan would be best stated as “continue to monitor PSA every six months to check for prostate recurrence.”

Consistency

Use caution when using record templates or electronic health records (EHRs) that might introduce conflicting or contradictory information. Many electronic health record (EHR) systems default to “normal” values that may conflict with previous “abnormal” entries.

Examples of conflicting or contradictory documentation include:

- The final assessment states right hemiparesis due to prior cerebrovascular accident, but the neurologic review of systems (ROS) and neurologic examination are noted as completely normal.
- The chief complaint states the patient presents for evaluation of chest pain, and the final assessment states acute angina. However, the review of systems states, “Patient denies any episodes of chest pain.”
- The office notes refer to the patient as both “he” and “she.”

Specificity

Avoid vague diagnosis descriptions, e.g. “other” or “unspecified.” Describe each final diagnosis to the highest level of specificity, such as:

- With or without exacerbation
- With or without complications
- Acute, chronic, acute-on-chronic versus chronic
- Severity – mild, moderate, severe
- Stages or types
- Controlled or uncontrolled
- Underlying cause
- Associated conditions
- Location or site, including laterality, specific site within a body part (upper outer quadrant, lower inner quadrant, etc.), distal, proximal, etc.

Examples:

Chronic kidney disease (CKD)

- Specify stage I-V or end-stage renal disease (ESRD)
- Even if lab values and/or the glomerular filtration rate (GFR) are documented, the record must still clearly specify the stage of CKD. Medical coders are not allowed to clinically interpret the GFR to code a stage of CKD.

Neoplasms – Specify:

- Site(s), including location within a body part (e.g., lower outer quadrant of right breast)
- Clear specification of which site is primary and which sites are secondary
- Histologic type (adenocarcinoma, squamous cell carcinoma, etc.) or behavior (benign, malignant, uncertain, etc.)
- Date of diagnosis with treatment chronology
- Current status and response to treatment, for example:
 - Resolved
 - In remission
 - Undergoing adjuvant therapy (specify whether curative, palliative or prophylactic/preventive)

Diabetes mellitus (DM)

- Specify type (Type 1, Type 2, secondary to – state the causal condition)
- Include status of diabetes control, as in “well controlled” or “uncontrolled due to hyperglycemia”
Note: ICD-10-CM considers “uncontrolled” to be a diabetic complication and requires the physician to specify “uncontrolled” as either hyperglycemia or hypoglycemia. Without this specification, a diagnosis code cannot be assigned, as the ICD-10-CM manual does not provide a code for diabetes stated as simply “uncontrolled.”
- Document with or without complications (fully describe each complication).
 - Complications should be clearly and directly linked to diabetes through use of linking terms such as “with,” “due to,” “secondary to,” “associated with,” “related to.”
Best practice: Document *each* complication of diabetes with the descriptor “diabetic,” as in “Type 2 diabetes mellitus with diabetic neuropathy and diabetic retinopathy.”
 - Avoid use of punctuation marks (e.g., slashes and commas) to separate conditions in a list of diabetic complications, as this may not clearly indicate a causal relationship.

Note: Ensure the medical record does not document diabetes as both *with* and *without* complications. This contradiction can occur when the EHR allows the provider to document a final diagnosis by choosing an ICD-10-CM code with description from a drop down menu. For example:

E11.9 Type 2 diabetes mellitus without complications

E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy

Note: The ICD-10-CM classification presumes cause-and-effect linkage between diabetes and certain conditions unless the physician specifically indicates the conditions are not related. Conditions that appear in the alphabetic index as indented subterms under the various types of “Diabetes, with” are coded as diabetic complications, even in the absence of physician documentation explicitly linking them, unless the documentation clearly indicates these conditions are not caused by diabetes – for example, by stating:

- The actual nondiabetes-related cause
- The cause is not diabetes
- Diabetes is without complications
- The cause is unknown

For more information related to coding these and other conditions, see Humana’s condition-specific coding guidelines.

Confirmed versus uncertain

Avoid use of terms that imply uncertainty (such as “probable,” “apparently,” “likely” or “consistent with”) to describe diagnoses or conditions that are confirmed. Rather, document the signs and symptoms in the absence of a confirmed diagnosis.

Status conditions

Document status conditions when applicable (e.g., ostomy status, dialysis status, amputation status, major organ transplant).

Final diagnostic statement

The assessment (a.k.a. impression) section in a medical record is the section in which the healthcare provider documents each of the patient’s final diagnoses based on all other information gathered as the patient was evaluated on an individual date of service. There should be only one final assessment; and it should document to the highest level of specificity all of the following:

- A final diagnostic statement for all conditions or diagnoses evaluated and managed on this date
- All comorbid or coexisting conditions that impacted patient care, treatment or management on this date
- Codes from the Tabular List titled “Other” or “Other specified” are for use when the information in the medical record provides a specific description of the condition but for which a specific code does not exist.
- The “Other” code with description should not be used, by itself, as a final diagnosis without clear documentation of the actual condition that describes the particular “other” condition

Electronic Health Record issues

Some EHRs insert ICD-10-CM codes with descriptions into the medical record to represent the final diagnosis. Example: “I42.8, Other cardiomyopathies.” This diagnosis is vague and incomplete.

ICD-10-CM Official Guidelines for Coding and Reporting advise as follows:

- Alphabetic Index entries in the ICD-10 coding manual with NEC (not elsewhere classified) designation represent “Other” codes in the Tabular List.
- These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.
- Codes from the Tabular List titled “Other” or “Other specified” are for use when the information in the medical record provides a specific description should not be used, by itself, as a final diagnosis without clear documentation of the actual condition that describes the particular “other” condition.

Another scenario that causes confusion is one in which the assessment section documents a provider-stated diagnosis *PLUS* an EHR-inserted ICD-10-CM with description that does not match – or may even contradict – the stated diagnosis.

Example:

Assessment: Cardiomyopathy

Keep follow-up appointment next week with cardiologist

I42.Ø Dilated cardiomyopathy

In this scenario, the provider’s final diagnostic statement in bold is simply, “Cardiomyopathy,” which codes to 142.9. The EHR-inserted diagnosis code with description – I42.Ø Dilated cardiomyopathy – does not match the stated diagnosis. To avoid confusion and ensure accurate diagnosis code assignment, the provider’s final

diagnosis must either match the code with description; or it must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.

Note: ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider’s final diagnostic statement. It is the healthcare provider’s responsibility to provide legible, clear, concise and specific documentation of each final diagnosis, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

Supporting documentation

The medical record should provide supporting documentation for each condition or diagnosis listed, such as:

- Related signs and symptoms and physical exam findings.
- Results of diagnostic testing, including the physician’s interpretation with indication of the clinical significance.
- Medication lists should document the drug name, dosage with times and/or frequency and clear linkage to the condition(s) for which the drug has been prescribed.

For chronic conditions that have impact on patient care, treatment and management but are being followed by a different healthcare provider, supporting documentation would be a simple notation to that effect. For example, “Chronic obstructive pulmonary disease (COPD), followed by Dr. Smith, pulmonologist.”

Treatment plan

The current plan of treatment for each diagnosis should be clearly documented and specific.

- Examples include dietary recommendations, medication changes, orders for diagnostic testing, specific patient education or counseling provided, continued monitoring and other factors that affect diagnosis.
- If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested.
- Document when it is planned to see the patient again, even if on an as-needed basis only.

Problem lists

Problem lists are a common element in medical records, especially EHRs. Unfortunately, there is no universally accepted definition of the naming, content or use of a problem list across all healthcare providers. Problem lists may contain both active and historical conditions, but they are not equivalent to a past medical history or final assessment/plan. The problem list should be maintained and updated by the healthcare provider, or there will be resulting questions about the status of the conditions in the list, and possibly the record, as a whole.

Best practice

- *Each condition on a problem list should be evaluated separately by the examining healthcare provider; documentation should reflect the evaluation, monitoring and treatment for each condition.*

Late entries and addenda

Changes to a medical record after the office visit is completed must comply with one of these two types of entries:

1. Late entries
 - Should be used for simple corrections to the original note, made within approximately 24 to 72 hours after providing service and before the claim is filed
 - Should be used for purposes of clarification, error correction or the addition of information not

initially available

- Should be dated and timed
- Should be written only if the person documenting has total recall of the omitted information

2. Addenda

- Should address additional clinically relevant information; not information just to meet regulatory requirements
- Should be used for information that was present at the time of the visit, but not available to the physician at the time of the original entry
- Should clearly identify content as separate from the original entry
- Should be timely (30 days is accepted)
- Needs to include the signature of the original healthcare provider and date
- Should include the reason for the addition or clarification

A final note

Industry-standard diagnosis coding guidelines require medical coders to apply a strict literal interpretation to the healthcare provider's medical record documentation. Coders are not allowed to "connect the dots," make assumptions or presume to know the healthcare provider's intent. Coders cannot apply a clinical interpretation to information within the record, such as diagnostic test results or physical exam findings. Accurate diagnosis code assignment is dependent on the healthcare provider clearly describing each medical diagnosis to the highest level of specificity.

References:

- American Hospital Association, or AHA, Coding Clinic
- ICD-10-CM Official Guidelines for Coding and Reporting
- CMS Medicare Program Integrity Manual