

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 assists physicians and other healthcare professionals in evaluating and planning the patient’s immediate treatment and monitoring 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 or ordered must be authenticated by the ordering practitioner.
 - 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.
- Realize 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.

Timelines and dates

Specific dates and timelines provide important information and can affect diagnosis code assignment (see second example 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.
- 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. For 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 prostate-specific antigen (PSA) lab test to monitor for recurrence. The assessment section should not state "prostate cancer," but rather "history of prostate cancer." The related plan should state, "Will continue to monitor PSA every six months to check for prostate cancer recurrence."

Consistency

Use caution when using record templates or electronic medical records (EMR) that might introduce conflicting or contradictory information. Many EMR 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," creating a consistency issue.

Specificity

Avoid vague diagnosis descriptions, e.g. "other" or "unspecified." Document each condition to the highest level of specificity, such as:

- With or without exacerbation
- With or without complications
- Acute versus chronic
- Severity – mild, moderate, severe
- Stages or types
- Controlled or uncontrolled
- Underlying cause
- 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 clearly specify the stage of CKD. Medical coders are not allowed to assign a stage of CKD based on the documented GFR.

Diabetes mellitus (DM)

- Specify type (Type 1, Type 2, secondary to – specify causal condition)
- Status of diabetes control, as in “well controlled” or “uncontrolled due to hyperglycemia” (ICD-10-CM considers “uncontrolled” to be a diabetic complication and requires the physician to specify “uncontrolled” as either hyperglycemia or hypoglycemia)
- With or without complications or manifestations (fully describe each complication or manifestation)

If there are complications or manifestations of diabetes mellitus, best practice is to clearly and directly link diabetes to those complications or manifestations using terms such as “with,” “due to,” “secondary to,” “associated with” and “related to.” Avoid the use of punctuation marks (e.g., slashes and commas) to separate diabetes and its manifestations, as they may not clearly indicate a causal relationship.

Best practice

- *Document each complication of diabetes with the descriptor “diabetic,” as in “diabetes mellitus type 2, well controlled, with diabetic neuropathy.”*

Neoplasms – Specify:

- Date of diagnosis/chronology
- Site (primary and/or secondary) within a body part/histologic type or behavior
- Course of/response to treatment
- Current status of the neoplasm (primary and/or secondary):
 - Resolved
 - In remission
 - Undergoing adjuvant therapy (specify whether curative, palliative or prophylactic)

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. Always 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, etc.).

Final diagnostic statement

This is the section of the record in which the healthcare provider states the final assessment or final impression of the patient's current 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/plan, and it should include:

- All conditions or diagnoses that impacted the patient's care on this date
- 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

Status of each condition that currently exists (not historical), such as improved, stable, worsening, in remission, etc. Documentation of a condition without a status is vague and does not clearly indicate whether the condition is current versus historical.

Electronic medical record (EMR) reminder

- Some electronic medical records insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis. Example: "I42.8, Other cardiomyopathies."
- With these types of vague descriptions, the diagnosis will not be complete unless the physician clearly documents the specific "other" condition.

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 a 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

Keep in mind that the record should provide supporting documentation for each condition or diagnosis listed. For example:

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

For chronic conditions that 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), under treatment by pulmonologist."

Treatment plan

Your current plan of treatment for each diagnosis should be clearly documented and specific. Examples should include dietary recommendations, medication changes, scheduling of 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 electronic health records (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