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 providers as follows:

"Clear and concise medical record documentation is critical to giving patients quality care and getting correct and prompt payment for services. Medical records chronologically report a patient's care and records related facts, findings, and observations about the patient's health history. Medical record documentation helps you evaluate and plan the patient's immediate treatment and watch their health care over time." (CMS, 2023a)

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

Legibility

- The entire medical record must be legible.
- Remember this basic rule: If it is not documented, it was not done.
- If it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and that appropriate medical services were performed.

Patient demographics

- Each page should include the date of service and the patient's name and date of birth.
- Include the patient identification number, if applicable.

Page numbering

Each page for each date of service should be numbered so that, if pages are separated, they may be easily reassembled in proper order.

Best practice

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Healthcare provider signature and credentials

- Only authorized personnel may document in the medical record and must be clearly identified by a printed, legible provider name and credentials.
- Each encounter must document the date of service and be signed in a timely manner by the rendering provider.
- Signature method shall be handwritten or electronic signature. Stamped signatures are not acceptable. CMS allows stamped signatures on handwritten records only when the provider can show proof of physical disability that renders them unable to sign the record. (CMS, 2023b)

Abbreviations and acronyms

- Limit the use of abbreviations and acronyms or avoid altogether.
- Use only industry-standard abbreviations and acronyms.
- Some standard abbreviations and acronyms have multiple meanings and can often be determined based on context, but this is not always true.

Best practice

- Initial notation of a diagnosis should be fully spelled out followed by the abbreviation in parentheses, such as myocardial infarction (MI) or rheumatoid arthritis (RA).
  - e.g., While MDD is a commonly accepted medical abbreviation for major depressive disorder, this abbreviation also can be used to represent manic depressive disorder, which classifies to a different diagnosis code.
- Subsequent mention of the condition can be made using the abbreviation.
- Diagnosis should be fully spelled out in the final assessment or plan.

Dates and timelines

Specific dates and timelines provide important information and can affect diagnosis code assignment.

- 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 an exacerbation of congestive heart failure."

  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 vague. ICD-10-CM Guidelines for Coding and Reporting, Section I.C.9.e.1 advises for encounters occurring while the myocardial infarction is equal to or less than four weeks old, code the MI as acute. For encounters after the four-week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21 (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 or ongoing. In diagnosis coding, "history of" means a condition occurred in the past and is no longer a current problem.

- To describe a current condition that is in remission document the condition as "in remission" and not historical. For example:
  - Patient with a history of prostate cancer that was eradicated in the past, presents to the office for evaluation, examination and six-month follow-up PSA (prostate-specific antigen) lab test to monitor for prostate cancer recurrence.
  - Assessment section should not state "prostate cancer," but rather "history of prostate cancer."
  - Related plan is best stated as "continue to monitor PSA every six months to check for prostate cancer recurrence."

Consistency

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

Examples of conflicting or contradictory documentation include:

- Final assessment states "right hemiparesis due to prior cerebrovascular accident (CVA)" but the neurologic review of systems (ROS) and detailed neurologic examination are noted as completely normal.
- 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."

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 and/or complications
- Primary, Secondary, Recurrent, In remission (partial or full)
- Acute, chronic, acute-on-chronic
- Severity – mild, moderate, severe
- Location or site, including laterality and specific site with a body part (upper outer quadrant, lower inner quadrant, etc.), distal, proximal, etc.

Causal relationship

- Medical record documentation should clearly link conditions like diabetes mellitus to related complications by using linking terms such as "due to," "secondary to," "caused by," and "associated with." These linking terms confirm the cause-and-effect relationship (versus the two conditions simply co-existing).
- 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.

The ICD-10-CM classification presumes cause-and-effect linkage between certain conditions unless the physician specifically indicates the conditions are not related. This is based on the coding convention outlined in the ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.15, regarding the term "with." Conditions that appear in the alphabetic index as indented subterms under the main term are coded as complications, even in the absence of physician documentation explicitly linking them, unless the documentation clearly indicates these conditions are not causal. For example:

- The actual condition-related cause
- The cause is not the main condition
- Condition is without complications
- The cause is unknown

Note: The "With" coding convention in Section I.A.15 of the Official Guidelines applies only to the coding path in the ICD-10-CM manual. It does not apply to the diagnosis description documented in the medical record. In other words, the words "with" or "in" used in medical record documentation do not have the same meaning as "with" or "in" as they appear within the ICD-10-CM coding manual.

For more information related to coding specific chronic conditions, see Humana's condition-specific coding guidelines.

Confirmed versus uncertain

ICD-10-CM Official Guidelines for Coding and Reporting, Section II.H. directs us to 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.

Note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

Status conditions

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

Assessment/Impression/Plan

This portion of a medical record is where the provider compiles their medical decision-making for the encounter and documents their visit diagnoses, treatment plan or referrals and any other plans for the encounter.

- There should only be one final assessment.
- Should document to highest level of specificity of the following:
  - A final diagnostic statement for all conditions, including how each condition was evaluated and managed during the encounter.
  - All comorbid or coexisting conditions that impacted patient care, treatment or management for that encounter.
  - Status of each condition that currently exists (not historical), such as improved, stable, worsening, in remission, etc.

Electronic health record (EHR) issues

Other and unspecified codes with descriptions:

Some EHRs insert ICD-10-CM codes with descriptions into the medical record to represent the final diagnosis and are vague descriptions and incomplete diagnoses. For example:

"I42.8 Other cardiomyopathies"

"I42.9 Cardiomyopathy, unspecified"

- Codes titled "other" or "other specified" are for use when the medical record provides a specific diagnosis description for which a specific code does not exist. The "other" ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation that specifies the particular "other" type of the condition.
- Unspecified diagnosis descriptions should be used only when sufficient clinical information is not known or available to the provider at the time of the encounter.
- A contradiction can occur when an EHR allows the provider to document a final diagnosis by choosing ICD-10-CM codes with descriptions from a drop-down menu. For example, some EHRs document both of the following final diagnoses:

  E11.9 Type 2 diabetes mellitus without complications

  E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy

Mismatch between final diagnosis and EHR-inserted diagnosis code with description:

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. For example:

Assessment: Ischemic cardiomyopathy
I42.Ø Dilated cardiomyopathy

The final **bold** diagnosis in the Assessment is "Ischemic cardiomyopathy," which codes to I25.5. The EHR-inserted diagnosis code with description that follows, however, is I42.Ø, Dilated cardiomyopathy, which causes confusion regarding which diagnosis is correct. Often documentation found elsewhere in the record does not provide clarity.

To 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 diagnosis. It is the healthcare provider's responsibility to provide legible, clear, and concise documentation of each final diagnosis described to the highest level of specificity, which is then translated to an ICD-10-CM 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 impacting patient care, treatment and management and are being followed by a different healthcare provider, supporting documentation would be a notation to that effect. 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 and can include:

- Dietary recommendations
- Medication changes
- Orders for lab/diagnostic testing
- Specific patient education or counseling provided
- Continued monitoring
- Other factors that affect diagnosis

Document specific details for referrals made or consultations requested. Document when the patient will be seen again, even if on an as-needed basis only.

Problem lists

Problem lists are a common element in medical records, especially EHRs. There is no universally accepted definition of the naming, content, or use of a problem list across all EHR's. 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, documented at every visit. This avoids confusion and questions about the status of the conditions in the list and possibly the medical record in its entirety.

Amendments, corrections and delayed entries

CMS advises regardless of whether a documentation submission originates from a paper record or an electronic health record, documents containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such.
2. Clearly indicate the date and author of any amendment, correction, or delayed entry.
3. Clearly identify all original content, without deletion.

When correcting a paper medical record, these principles are generally accomplished by:

1. Using a single line strike through so the original content is still legible, and
2. The author of the alteration must sign and date the revision.
3. May be initialed and dated if the medical record contains evidence associating the provider's initials with their name (e.g., separate signature log).

Records sourced from electronic systems containing amendments, corrections or delayed entries must:

1. Distinctly identify any amendment, correction or delayed entry; and
2. Provide a reliable means to clearly identify the original and modified content, and the date and authorship of each modification of the record. (CMS, 2023c)

Delayed or amended entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service. (Winter, 2006)

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 clinically interpret information within the record, such as diagnostic test results or physical exam findings, to assign a code for a diagnosis that is not documented in the record. Accurate diagnosis code assignment is dependent on the healthcare provider clearly describing each medical diagnosis to the highest level of specificity.

Disclaimer

This document is intended for physicians and office staff. The information here is not intended to serve as official coding or legal advice. All coding should be considered on a case-by-case basis and should be supported by medical necessity and the appropriate documentation in the medical record.

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