DOCUMENTATION AND CODING

Guidelines for Medical Records

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"Code *all* documented conditions that coexist at the time of the encounter/visit *and* require or affect patient care, treatment, or management." – *ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.J*

Document and code chronic conditions as often as they are assessed or impact the decision making of the visit

The signed, complete and accurate clinical detail of a patient's disease burden is the key to any successful practice. As a legal document for continuity of care, coding and claims submission, the medical record has certain standards to uphold. Components of supportive documentation include:

- Patient's name, identifier (such as DOB) and date of service (DOS) on each page
- Details that enable coding to the highest level of specificity
- Treatment and/or management for each condition
- Written diagnosis – not just ICD-10-CM codes
- Provider signature, credentials and date signed

Diagnosis

- Proper diagnosis coding and submission is dependent upon the medical record documentation
- Conditions may not be assumed or implied

Manifestations and Complications

- Document conditions that have a causal relationship as "due to" "caused by" "secondary to" or other term that indicates the connection
- Simply listing diagnoses in the assessment may not link the underlying conditions

Condition history

- The statement "history of" indicates that the condition no longer exists
- Documenting historic conditions as current or current conditions as historic leads to missed or improper diagnosis coding

Permanent Conditions

- Permanent conditions should be documented and coded as status if they affect the visit
- Examples include amputation and organ transplant

WHEN DOCUMENTING, KEEP IN MIND **DSP**:

- **Diagnosis** – Document all conditions to the highest level of specificity
- **Status** – Stable, worsening, improving, (un)controlled
- **Plan** – Treatment, referral, follow-up

Unconfirmed Diagnosis

- Only a confirmed diagnosis can be coded in an outpatient setting
- If a diagnosis is not confirmed, document and code the highest level of certainty such as signs, symptoms, abnormal test results or other reason for the visit
- Do not document as "rule out," "probable," "suspected" or other unconfirmed diagnosis term

Acronyms and abbreviations

- Use only standard medical abbreviations
- Be cautious of acronyms with multiple meanings
- Do not use symbols such as up and down arrows

Legibility

- All medical records must be legible to the average reader
- If the condition is not legible, it cannot be coded
- In the event of an audit, illegible records will not be considered supportive documentation and claims may be denied

Telehealth Visits

- Documentation must indicate whether audio, video or audio/video
- Start and end times should be documented

Specificity

- In order to assign the appropriate ICD-10-CM diagnosis code, documentation must be as specific as possible
- Absence of detail could lead to incomplete or unspecified diagnosis coding

Documenting Detail		
Laterality	Episode of Care	Severity
Complications	Timing	Contributing Factors
Cause and Effect	Associated Conditions	Location
Comorbidities	Status	Manifestations
Trimester of Pregnancy	Lifestyle	Sequelae (Late Effects)
Acute and/or Chronic	Tobacco Use/ Exposure	Organism and/or Agent