



COMPLETE DIAGNOSIS SUBMISSION IMPROVES QUALITY & CARE

Remember these important Dos and Don'ts of medical record documentation and coding.

DOCUMENTATION TIPS:

- DO fully assess all chronic conditions **at least** once a year to assure that the patient's conditions are being properly monitored.
- DO only document those conditions that were evaluated during each visit. The medical record for each visit must be able to stand on its own, so this requires the documentation of each visit to be complete.
- DO use terms within the medical record to denote that a condition was evaluated including phrases such as:
 - Stable on medications;
 - Condition worsening;
 - Medication adjusted;
 - Tests ordered and results reviewed;
 - Condition improving.
- DO use phrases that show the cause and effect which must be documented in the medical record. Cause and effect is documented when the specific disease is also followed by one of the following phrases:
 - Due to
 - Associated with
 - Secondary to
- DO remember the 4 "C's" in medical record documentation -- Clear, Concise, Consistent and Complete
- DO write legibly.
- DO sign and date each entry.
- DO code a condition *only* when it is certain.
- DO document all of the conditions present when the patient is a complex case. For example: COPD, CHF, Diabetes with Neuropathy & nephrosis. Complex patients require special attention when you are documenting and coding their medical record.
- DO document and code for all secondary or associated diagnoses when possible.
- DO remember that if it is NOT documented in the medical record, then it did NOT happen.
- DON'T enter a list of the medications that the member is taking in the medical record as proof that a condition was evaluated. A medication list does not mean that an evaluation occurred for the condition for which the medication is used.
- DON'T use the term "with" to support the cause and effect of a specific disease.
- DON'T code probable, suspected, ruled out or working diagnoses.

CODING TIPS:

- DO code the diagnosis to the highest level of specificity using the ICD-9-CM diagnosis coding system.
- DO code as many times as the patient receives treatment and care for a chronic condition.
- DO code every condition that exists at the time of the encounter when that condition results in or affects patient care, treatment or management and when the conditions are addressed in the medical record for that encounter or specified visit.
- DO remember ICD-9-CM Coding Guidelines may require multiple conditions to be combined into one code. For example: hypertensive heart disease with congestive heart failure: 402.91
- DO follow instructions to fully code all conditions when "code also," "code first" or "use additional code" are specified within the ICD-9-CM manual for a code. For example: Patient has dementia with multiple sclerosis. This requires two codes to be used:
 - a. Multiple Sclerosis: 340
 - b. Manifestation of Dementia: 294.10
- DON'T code conditions that were previously treated and no longer exist.