Medical Record Documentation Tips

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For Medicare Advantage risk adjustment purposes, diagnoses submitted to the Centers for Medicare & Medicaid Services (CMS) should be documented in the medical record and the result of a face-to-face visit. Diagnoses should be coded according to *International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting*.

Medical record documentation should include:

- Patient's name and date of service (DOS) on each page
- ALL health conditions including those that coexist at the time of the visit, such as chronic and status conditions
- Details to code each condition to the highest degree of specificity
- Patient care treatment and/or management for each condition
- Provider's signature, credentials and date signed
- Information that is **clear, concise, consistent, complete and legible**

It is the responsibility of each provider to document clearly and precisely for each patient visit. Documenting all health conditions on an annual basis provides a more complete and accurate picture of the patient's overall health status.

State the diagnosis

- Medical record documentation dictates diagnosis code assignment(s).
- A diagnosis can only be coded if it is explicitly stated by the provider in the documentation for the current visit.
- The diagnosis must be stated in text and cannot be inferred from lab values, medications, radiology reports, patient statements, up and down arrows (↑↓) or other symbols.

Specificity

- Documentation must be as specific as possible to code to the highest level of specificity in ICD-10.
- Absence of this extra level of detail in the documentation could lead to an unspecified diagnosis code assignment.

Example:
A diagnosis of kidney disease is not as specific as a diagnosis of stage 4 chronic kidney disease.

Examples of documenting detail:	
Acute and/or chronic	Late effects (sequela)
Agent and/or organism	Laterality
Anatomical location	Lifestyle
Associated conditions	Manifestations
Cause and effect	Remission status
Comorbidities	Severity
Complications	Timing
Contributing factors	Tobacco use/exposure
Episode of care	Trimester of pregnancy

Linking verbiage for manifestations

- When documenting conditions that have a causal relationship, use linking verbiage to connect the two conditions, such as "with," "secondary to," "due to," or "associated with."

Example:
Left-sided hemiparesis due to previous stroke

Status of condition

- Documenting the terms "history of" is an indication that the condition no longer exists.
- Listing historic conditions as current or listing current conditions as historic under past medical history causes many diagnosis codes to be missed or improperly coded.
- Remember to document chronic, ongoing conditions as often as they are a consideration in the patient's care treatment and/or management.

Instead of documenting…	Document in the following manner:
History of diabetes	Patient with DM since 2009
History of CHF, meds	History of CHF, meds compensated CHF, stable on meds
History of COPD	COPD controlled with inhaler
Stroke	Patient with history of stroke two years ago

Abbreviations and acronyms

- Use only standard abbreviations and acronyms.
- To prevent diagnosis coding errors, spell out diagnoses as abbreviations and acronyms may have different meanings.

Legibility

- Handwritten charts can be problematic due to the subjective nature of interpretation.
- If the diagnosis is illegible, it cannot be coded.

The forgotten ones

- Frequently overlooked but significant and/or permanent status conditions that risk adjust include,but are not limited to:
  - Lower limb amputation status.
  - Organ transplant status.
  - Dialysis status.
  - Artificial opening status.
  - HIV status.

Unconfirmed diagnosis

- Listing a differential diagnosis as though it already exists or is confirmed can lead to coding errors.
- Terms such as "possible," "appears to be" and "suspected" indicate uncertainty; a diagnosis must be confirmed to be coded in an outpatient setting.
- For an unconfirmed diagnosis, code assignment should reflect the highest degree of certainty such as signs, symptoms, abnormal test results or other reason for the visit.

Resources

1 *CMS Medicare Managed Care Manual*, Chapter 7, Section 40
2 ICD-10-CM Codebook

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