BEST PRACTICES

Physician Documentation

This teaching tool addresses common coding and compliance shortcomings. Minor changes to documentation habits can lead to greater accuracy in abstraction, better compliance, and more appropriate risk scores, quality ratings, and reimbursement.

Documentation Tips

- **Do not use "history of"** to describe a known, active condition. In ICD-10-CM, "history of" always describes a condition that is resolved. Instead of saying "history of," quantify the continuum of care (eg, "Mr. Doe is being seen today for his Parkinson's disease, first diagnosed 7 years ago.").
- **Do not use "history of"** to describe a condition in remission. Instead, document "in remission."
- **Consider each encounter** as a stand-alone account of the patient's health and document accordingly. Coders are not permitted to seek clarity from previous encounter notes.
- **Use an Assessment/Plan format** that clearly aligns each diagnosis to a treatment plan. Example:

Assessment	Plan
1. Type 2 diabetes mellitus	1. Metformin, 500 mg bid; draw A1C in 3 months
2. CKD, stage 3	2. Staff set up appointment with nephrology clinic
3. Bilateral osteoarthritis, knees	3. Patient to continue naproxen as directed

- **Think in ink.** Chronic conditions affect the chief complaint in almost all cases, and physicians think about them, but may not write about them. Document how each chronic condition is affected (eg, "Diabetes is in good control despite pneumonia. Blood glucose today is 105.").
- **Use linking language for related conditions:** "Aphagia due to CVA" rather than "Aphagia and CVA."
- **Specifically identify any complication** and clearly document what caused the complication.
- **State the obvious.** Do not document "GFR of 48." Instead, document, "Chronic kidney disease (CKD) stage 3, GFR of 48." Coders are not permitted to connect the dots or code from laboratory values.
- **Ensure documentation is unique to the encounter.** Use cut-and-paste function with caution!
- **Be specific.** Is the condition acute or chronic? What is the cause? Where is the bleeding? Drug "abuse" or "dependence"? Details yield different diagnostic codes and affect risk scores.
- **Acknowledge pertinent laboratory or radiology results** in the body of the documentation.
- **Document status conditions** at least annually and whenever they affect care and/or are evaluated:

Document These Status Conditions	
Amputation	Asymptomatic HIV status
Dependence on respirator	Dialysis
Ostomy	Transplant
Intellectual disability	History of myocardial infarction

- **Do not say "All systems negative."** Name specific systems reviewed.
- **Document time** when more than 10 minutes have been spent face-to-face with the patient.
- **Tell the whole story.** If physicians do not record what they did, they cannot be paid for it.
- **Review and update problem lists and medication lists** and document having done so.
- **Check administrative details.** Electronic signatures require name, credentials, and date. Written signatures must be legible with credentials.
- **Review and update problem lists** and address each chronic condition at least yearly.

BEST PRACTICES

Coder Abstraction

Proper code look-up affects code selection, which can affect the physician's compliance and reimbursement. The patients are affected too, as the codes assigned become part of their permanent health record.

Coding Tips

- **Follow the instructions** in coding references, including guidelines, chapter-level instructions, and code-specific instructions. Follow the AHA's *Coding Clinic* for guidance.
- **Don't stop at the Alphabetic Index.** The Index points to the correct direction, but it does not always give the exact code. Look up the code in the Tabular Section after finding it in the Index.
- **Pay attention to who is "talking."** Do not code patients' self-diagnoses. Do not code diagnoses written by medical assistant or nurse. Code only diagnoses documented by the physician or other acceptable provider.
- **Watch out for "cloning."** Be aware of what is unique to the current encounter and what is copied from previous encounters. Some electronic health records (EHRs) pull information forward automatically. Do not code from information that has not been referenced or updated by the physician during the current encounter.

Chronic Diseases Rule

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care of the condition(s).

- **Check physician coding.** If a physician assigns codes in documentation, check them. The physician is the expert clinician, while coders are the experts at coding. The physician's words matter more than the codes they select or document. Documented codes without language describing the diagnosis cannot be abstracted.
- **Never make assumptions** about what the note means. A blood glucose reading of 900 cannot be reported as hyperglycemia, unless the physician documents it as such. Query the physician, and the physician can amend the note to reflect the condition, if appropriate; only then can it be coded.

Uncertain or Differential Diagnoses

In the outpatient environment, do not code diagnoses documented as "probable," "suspected," "questionable," "rule-out," or "working" diagnoses. Do not code "differential" diagnoses.

- **Link related conditions** when they are documented as related. Use the Alphabetic Index to determine which conditions are automatically linked by the "with" convention in the ICD-10-CM guidelines.
- **Search and research the Internet** often to understand medications and conditions referenced in documentation. Medscape, National Institutes of Health, and MedlinePlus are dependable resources.
- **Use language** found in the documentation when searching the Alphabetic Index.
- **Read the entire note.** Often, diagnoses are buried within the operative or physical examination notes. Do not rely solely on the assessment.
- **Do not depend completely on software code-lookup programs.** These are not always complete.
- **Always code these status conditions** when present: ostomy, dialysis, HIV positive, transplant, amputation, dependence on respirator.
- **Update codebooks,** resources**,** and software for ICD-10-CM effective October 1 of each year.
- **A rule of thumb for coding:** If a patient is on medication for a condition, and the condition would return if medication were stopped, code the condition.
- **Never code from superbills.**