healthfirst
Health Insurance for New Yorkers

Documentation and Coding: Do's and Don'ts

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At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.

Chief Complaint (CC)	**Don't** leave chief complaint incomplete, blank, or not recorded. CC should not state: patient is here for refills, patient is here for follow up.	**Do** document the detail of CC by including the condition for follow up.
History of Present Illness (HPI)	**Don't** document insufficient history of present illness.	**Do** document the detail of HPI (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Sign, and Symptoms).
Physical Examination	**Don't** include information that is incongruent and/or conflicting in the physical exam. If using the templates, providers must update the template with current exam findings.	**Do** document the physical exam of system/organ problems in details (Inspection, Palpation, Percussion, Auscultation).
Assessment Plan	**Don't** include diagnoses in the assessment plan that are not supported by Monitoring, Evaluating, Assessing, and Treatment (MEAT).	**Do** document all conditions assessed with a status and MEAT.

Coding Tips

- Code all documented conditions that coexist at the time of the encounter/visit.
- Medical Necessity and Clinical Documentation Improvement are the key components of the correct diagnosis coding and reporting for audit.
- History codes (categories Z80–Z87) need to be used when conditions were previously treated and no longer exist.

Documentation and Coding:
Do's and Dont's

High-Quality Clinical Documentation Tips

Complete	Detailed documentation with the provider fully addressing all concerns in the patient record
Consistent	Non-contradicting/conflicting documentation
Timely	Prepared, signed, and dated by the provider at the time the care was provided
Clear	Thorough description of what occurred with the patient
Precise	Clearly defined by documentation of the highest level of specificity that can be determined from the clinical evidence
Legible	Clear and easy for the reader to interpret
Reliable	Trustworthy documentation

How can the electronic health record (EHR) impact Clinical Documentation?

Significant challenges with electronic documentation include:

- Some providers only look in the EHR for information/communication, which can cause a lack of communication in their workflow
  - Cutting and pasting prior documentation into new records can obscure new information and increase audit risks
- Symptoms, not diagnoses, are often documented
- Providers can't find correct diagnosis from pick list

Questions?

Contact us at **#Risk_Adjustments_and_clinical_Documentation@healthfirst.org**.

For additional documentation and coding guidance, please visit the Coding section at **hfproviders.org**.

References:
ICD-10-CM Official Guidelines for Coding and Reporting; AAPC.com; AHIMA.org

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