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Best Practices for Documentation

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 **Best Practices for Documentation** and ICD-10-CM selection. According to Centers for Medicare & Medicaid Services (CMS) recommendations and ICD-10-CM Coding Guidelines: "Consistent and complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved." This document does not represent or guarantee that Healthfirst will cover and/or pay for the 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 amount that Healthfirst or the member owes the provider.

Common Documentation Issues and Best Practices

Issue	Description
Historical versus Current	Avoid using the descriptor "History of" when documenting a condition that is current and active. In ICD-10-CM diagnosis coding "history of" indicates the condition is historical and no longer exists. **Best Practice:** ✓ Do not use "History of" to describe an active condition. ✓ Use terms which indicate a condition is actively being treated: "patient with," "patient has."

Issue	Description
Specificity	According to ICD-10-CM Guidelines, diagnosis codes are to be used and reported to the highest level of specificity documented in the medical record. This instruction highlights how crucial accurate documentation is to achieve accurate diagnosis code assignment. **Best Practice:** ✓ Avoid vague diagnosis descriptors, such as “other” or “unspecified.” ✓ Document: o Acuity, chronicity, and complications when known. o Location and site, including laterality of an affected body area. o Severity of conditions when known- ex. stage, mild, moderate, severe. **Example**: **Chronic Kidney Disease (CKD) - Specify stage I-V or End Stage Renal Disease** Even if lab values, such as the glomerular filtration rate (GFR) are documented, the medical record must clearly specify the stage of CKD. Medical coders are not allowed to clinically interpret lab values to code a stage or severity.
Confirmed versus Uncertain Diagnosis	According to ICD-10-CM conditions documented with uncertainty in the outpatient setting may not be coded and reported. **Best Practice:** ✓ Avoid using terms of uncertainty such as: probable consistent with. ✓ As an alternative, document the signs and symptoms in absence of a confirmed diagnosis.
Status Conditions	Document all status conditions when present at least once per annum. **Best Practice:** ✓ Status’ may include hemodialysis, amputation, ostomy, organ transplant.

Issue	Description
Abbreviations and Acronyms	Some abbreviations and acronyms may have multiple meanings which can lead to unclear documentation in the medical record. Example: “MDD” can represent “Major Depressive Disorder” or “Manic Depressive Disorder.” **Best Practice:** ✓ Limit abbreviations and acronyms or avoid altogether. ✓ The initial note of a diagnosis should be spelled out with the abbreviation in parentheses.
Problem Lists	Problem lists are a common element in the medical record which often gets overlooked during documentation and charting. **Best Practice:** ✓ The problem list should be updated during each encounter to avoid outdated/inaccurate information and to keep consistency within the medical record.
Assessment and Treatment Plan	The provider’s final impression impacting the patient during the encounter should be clearly identified and documented. **Best Practice:** ✓ All comorbid conditions or coexisting conditions that impact patient care, treatment or management should be documented, coded, and reported. ✓ Update treatment plans as appropriate such as: referrals, consultations, medication changes, orders/diagnostic testing, dietary recommendations.

Issue	Description
Supporting Documentation/ Medical Necessity	The medical record should always provide supporting documentation/medical necessity for each condition or diagnosis evaluated. **Best Practice:** ✓ Include any physical exam findings, results of diagnostic testing, along with physician interpretation and clinical significance. ✓ Medication lists should include clear linkage to the condition(s) for which the drug has been prescribed. ✓ Chronic conditions which impact patient care but are being followed by a specialist can be supported by a simple notation: “Type II Diabetes Mellitus followed by Dr. Emory, Endocrinology.”
Delayed Entries/ Addenda	On occasion, documentation will need to be amended, corrected, or entered after rendering the service. **Best Practice:** ✓ Services provided to patients are expected to be documented at the time of service. ✓ Delayed Entries and Addenda should: o Be authenticated with signature, date, and time. o Clearly identify content which is separate from the original entry. o Address additional information, not entered by the physician during the original entry or for purposes of clarification.

Key Components for the Medical Record

Component	Description
Patient Identifier	Patient identification is an essential piece to the integrity and reliability of medical record documentation. **Best Practice:** ✓ Two patient identifiers are included on every page **Example:** Name and Date of Birth
Numbered Pages	Pages of medical records should be numbered in sequential order; This allows for an objective reviewer to easily identify that the medical record is complete. If any pages of the medical record are missing, separated, or incorrectly ordered, this numbering system allows for the record to be reassembled.
Date of Service	A clear date of service must be displayed on all pages, any records which are missing a date of service are deemed invalid. **Best practice:** ✓ Avoid using invalid dates of service. Dates such as: fax date, dictation or signature date, or review date, are not considered synonymous with the date of service.
Signature and Credentials	Medical record entries must be complete and authenticated by the physician/practitioner who is responsible for ordering, providing, or evaluating the services furnished. **Best Practice:** ✓ Each date of service must be signed in a timely manner along with a legible signature and credentials. ✓ All signatures must be handwritten or Electronic. ✓ As per CMS, stamped signatures are not acceptable; exceptions include providers with proven disabilities.

Component	Description
Legibility	The entire medical record must be legible to accurately abstract diagnoses. If documentation is lacking and coding cannot be abstracted, it is as if the service was not rendered. Likewise, if the record is illegible the diagnoses cannot be captured. **Remember:** An illegible medical record is of no use in assigning diagnosis codes or determining the services which were performed.

References

- https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf
- https://www.cms.gov/files/document/medical-record-reviewer-guidance-january-2020.pdf
- https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/pim83c03.pdf

Questions?

Contact us at #Risk_Adjustments_and_clinical_Documentation@healthfirst.org.

For additional documentation and coding guidance, please visit the coding section on HFproviders.org