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Discharge Summary

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 the documentation and ICD-10-CM selection on services submitted to Healthfirst—specifically for **Discharge Summary**. It provides information from industry sources about proper coding practice. However, 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.

A **discharge summary** is a document that summarizes a patient's hospital stay and care plan and is typically completed on the day the patient leaves the hospital.

Essential Components of a High-Quality Discharge Summary • A discharge summary serves as a crucial communication tool that bridges inpatient care with post-discharge follow-up. For optimal continuity and quality of care, each summary should be clear, detailed, and clinically precise. Below are the core elements to include:
Patient Identification • Full name, age, sex, medical record number • Dates of admission and discharge • Names of primary and consulting providers
Reason for Admission • Presenting symptoms or chief complaint • Initial working diagnosis or cause for hospitalization
Clinical Background • Summary of current illness • Relevant past medical, surgical, family, and social history
Inpatient Course • Key diagnostic findings, procedures, and interventions • Specialist consultations and treatment responses • Any complications or changes in clinical status

Medications at Discharge
- Full, reconciled list of medications
- Dose, route, and frequency
- Notes on newly prescribed versus continued medications

Post-Discharge Instructions
- Follow-up visits with providers or services
- Diet, activity, and lifestyle recommendations
- Signs or symptoms warranting urgent care

Discharge Disposition
- Final diagnosis and summary of condition at discharge
- Where the patient is being discharged to (e.g., home, rehab)

Attestation
- Signature and date from the discharging provider

Additional Transitional Care Considerations
- In support of safer handoffs and more informed aftercare, include:
- An assessment of the patient's mental and cognitive function
- Emergency plan with contact information for urgent guidance
- A summary of expected care goals and prognosis
- Documentation of any advanced care plans or legal directives
- Equipment or special care instructions (e.g., wound care, oxygen)
- An evaluation of caregiver capacity and needs at home

Documentation Best Practices
- To ensure the discharge summary supports clinical, legal, and billing requirements:
- Write in straightforward, jargon-free language that is accessible to all members of the care team
- Avoid ambiguous abbreviations or shorthand
- Emphasize critical decisions, turning points in care, and follow-up needs
- Reconcile all medications and clarify changes from pre-admission regimens
- Review the entire patient record to confirm accuracy and completeness
- Use the summary to convey the rationale behind care choices to support downstream providers

A well-prepared discharge summary not only supports safer transitions but also plays a vital role in documentation integrity, risk management, and compliance with reimbursement protocols.

References

- Discharge Summaries Make a Difference – ICD10monitor (medlearn.com)
- Documentation of Mandated Discharge Summary Components
- Improving the Quality and Content of Discharge Summaries

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