Industry Collaboration Effort
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Communication for Collaboration

Documentation Hints
2nd Edition

The first Documentation Newsletter highlighted the basics of quality documentation. This newsletter will concentrate on Specialty Documentation.

The goal of complete and accurate documentation in progress notes is to help CMS evaluate the costs of taking care of the patient and pay Medicare Advantage plans accordingly. The goal is not to justify the CPT codes or E/M office visits that the physician bills.

Documentation Tips by SPECIALTY

Endocrinology

- Always document the most frequent manifestations or complications and link to underlying cause. These conditions require two codes.
  - Diabetic nephropathy or CKD caused by DM
  - Diabetic neuropathy
  - PVD due to diabetes
  - Diabetic retinopathy
  - Diabetic ulcers or bone changes

Cardiology

- Be specific if possible. CAD or ASCVD are general terms. Document the underlying cause.
  - Chronic conditions need specific definition and the intervention such as medication, referral, etc.
- CAD is a big bucket, list the specific or underlying condition
  - CAD, A Fib
  - CAD, Old MI 4/2005

Oncology

- Be specific and note all metastases as well as primary site.
  - Note status - active, under treatment, in remission, under surveillance, history of
  - Indicate all mets sites (from and to)   Example – History of breast cancer (V10.3) with current metastasis to brain, inoperable (198.3).

Vascular

- Be careful about tense
  - Acute CVA is generally in the emergency room or hospital. If you code CVA in your office you need to document that the patient is having a stroke in your office.
- Document all late effects of CVA for as long as they last. If there are no residual deficits then state that.
  - Hemiplegia, Dysphagia, Aphagia, monoplegia

Neurology

- Be specific when documenting neuropathy as there are many types
  - Peripheral neuropathy
  - Neuropathy due to diabetes
  - Autonomic neuropathy
  - Polyneuropathy

Nutrition

- Assess and document with treatment plan
  - Patients with CHF, COPD, renal failure, depression, alcoholism and cancer are often malnourished
  - Use albumin, unintentional weight loss > 10% and BMI when diagnosing malnutrition

Renal

- Look for CKD and note the stage
  - Stages I-IV based on GFR
  - Note if patient is on hemodialysis
  - Look for the cause of the CKD such as diabetes or hypertension and document and code the cause and effect. Example: hypertensive heart disease

Pulmonary

- Note all chronic conditions with treatment plan
  - Asthma and bronchitis – chronic or acute?
  - Document pathogens when known (i.e. cause pneumonia)
  - Yearly spirometry to access severity
  - Smoker's cough

Skin and Orthopedics

- Look for chronic conditions
  - Chronic skin ulcers – due to PVD or diabetes?
  - Pressure / decubitis ulcers – must document stage also
  - Amputations or amputation status
  - Pathologic vertebral fractures – acute vs. old

Psychiatric

- Document all conditions each time you code and address them.
  - Lifetime illnesses such as schizophrenia and bipolar
  - Major depression: single, recurrent, or lifetime?
  - Alcohol and drug dependence (would go through withdrawal if they stopped suddenly) vs. abuse. Is the dependency current, in remission, severe, moderate?
  - Melancholia
  - Episodic mood disorder

Gastroenterology

- Be sure to address GI conditions for as long as they exist
  - Hepatitis, Liver Disease, Cirrhosis, Colitis
- Proper documentation of the condition leads to proper coding
  - Acute, Chronic, Ulcerative
  - Specify Type
  - Cause- Alcoholic vs. non alcoholic? Chronic hepatitis C vs. hepatitis unspecified?

General documentation tips

- Always document the status of each diagnosis using adjectives (descriptive words) such as stable, controlled, compensated, improving, acute, chronic, worsening, etc.
- Always include a treatment plan using words such as continue, increase, decrease, add "name of medication", refer to _____, RTC or F/U, etc.
  - At a minimum, include a brief statement that updates the status of each diagnosis.
- Use the word history to mean that the condition no longer exists, not that the medical history of the patient includes these conditions. History of diabetes, CHF or COPD is not correct in most cases.
- Examples:
  - Diabetic nephropathy – refer to nephrologist
  - A Fib – rate well-controlled continue on Coumadin
  - CHF – stable, continue Lasix, monitor edema
  - History of MI in 2002 – continues to be stable and pain free

- It is also good practice to document not only the medications' dose and directions, but also the reason the patient is taking them. For example, "Coumadin 5 mg Monday, Wednesday, Friday, 3 mg other days for atrial fibrillation." Your physician might not be taking a lab sample that day or running an EKG, but if he is mentioning the condition in the med list it supports the fact that it plays into his medical decision making and then it can be coded when he documents it in a progress note.
- All medication listed should have the reason they are taking it.

Principles of Documentation

- Be complete and legible – it must be readable to someone else
- Include patient name, DOB and date of service on each page
- Note chief complaint (CC), reason for visit, assessment, and plan of care
- Specify basis for ordering ancillary / diagnostic services
- Indicate appropriate health risk factors
- Indicate past and present diagnoses if still of any medical significance
- Show patient's progress or lack of progress
- Substantiate service rendered
- Sign the progress note with full name and credentials
  - This will substantiate the services provided.
- Problem list should be up-to-date and include onset and end dates