Quick Tips for Better Coding Documentation
Improving Understanding Between Providers & Coders

It is essential for providers and coders to have a collaborative relationship, working toward a common goal of complete/accurate coding and positive reimbursement results, as supported by medical documentation. Here are some helpful tips for improved documentation, which can lead to enhanced patient care and improved reimbursement. If you have questions regarding this information, please contact our Revenue Integrity Department at 1-585-453-6465.

1. Be Legible
   Please be sure to make the documentation as neat and legible as possible. The better coders are able to read the documentation, the better the chances of capturing all applicable diagnosis codes.

2. Include Information About Medications
   Documenting a patient’s current medications is helpful if the record indicates which medication is associated with a diagnosis. Because many medications can be used to treat a variety of conditions, it is important to clearly link each medication with the condition it is addressing.

3. Document Historical vs. Current
   Certain conditions, such as cancer, stroke and myocardial infarction have codes dependent on the timing/status of the condition. Therefore, the record should indicate the date of occurrence and, if possible, differentiate between “historical” and “current” conditions.

4. Avoid Overusing “History Of”
   For coders, “history of” should only be used when a patient had a condition at one point, but no longer has that condition. In other words, “history of” is similar to “resolved.” If a patient still has a condition, please make this clear.

5. Clearly State Linked Conditions
   If a patient has one condition that is caused by, due to, or a manifestation of another condition, be sure to make this clear. Often times, linked conditions or secondary conditions have different codes, and it is important that the record clearly indicates when conditions are linked to ensure proper coding.

6. Remember “M.E.A.T”
   Be sure to indicate with your diagnoses what is being done to Monitor, Evaluate, Assess, or Treat a condition, so as to show that you have addressed each condition during that encounter.

7. Indicate Status
   Many conditions inadvertently get left off a patient’s medical record though they are ongoing. These include quadriplegia, paraplegia, amputation, dialysis status, AIDS or HIV status, and more. It is helpful to document these conditions at least annually and to include an indication of the patient’s status.

8. Differentiate Cancer
   For cancer, it is helpful for the record to clearly indicate whether a patient has primary or secondary cancer. Furthermore, coding guidelines dictate that current malignancy should only be coded when there is evidence of active disease (that is, until the patient has completed definitive treatment or if the patient declines treatment).

9. Include Patient Information
   Records may not be acceptable for coding purposes if a patient’s identifying information (name, date of birth, medical record number, etc.) is not present on every page of the record. It is important to verify that all pages of the record contain at least two patient identifiers.

10. Be Specific
    With the coming implementation of ICD-10-CM, specificity in diagnosis is more crucial than ever to ensure proper coding. Laterality, size, location, and other details all may lead to different ICD-10 codes, so it is important that the medical record reflect these variances.