East Jefferson General Hospital

General Documentation Tips

January 2019

Clear, consistent and relevant physician documentation is essential to translate patient care into codes that truly represent the clinical picture and support medical necessity.

- Provide detailed descriptions of chief complaint and presenting/associated symptoms in the HPI and ROS
- Document risk of adverse event: Uncertainty of diagnosis, differential diagnoses, risk of delay
- Document all comorbidities and all conditions being actively managed
- Document acuity, severity, specificity, laterality and linkage between conditions
- Document current medical needs/plan of care: Testing, monitoring, reassessments, interventions
- Avoid inconsistencies and contradictions: Patient with acute respiratory failure described in no acute distress, resting comfortably on physical exam
- Document resolved versus ruled out conditions
- Avoid copy and paste: Document daily why the patient is still in the status he or she is in and why they are getting the treatment they are getting that day.
- Identify what is preventing transfer to a lower level of care or discharge

Consider the definition of medical necessity provided by CMS: "…no Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

In order to support medical necessity, documentation of medical care provided should:

- Accurately reflect the need for and outcome of treatment
- Make the patient look as sick in the electronic medical record as they are in the hospital bed.

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