East Jefferson General Hospital

Documentation Tips: The Basics

August 2020

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

CDI Top Ten Documentation Do's:

1. Be Specific: risk adjustment
    - CAP ***versus*** Pneumonia due to Streptococcal pneumonia
    - Obesity ***versus*** morbid obesity
    - Type 2 DM not controlled ***versus*** Type2 DM with hyperglycemia
2. Probable, likely, and Suspected diagnoses are acceptable but, must be documented in the DC Summary
3. Avoid "history of" instead consider "chronic" or "as a late effect"
4. Document queried diagnosis in notes
5. Document Present on Admission (POA)
6. Be consistent: Patient with acute respiratory failure described in no acute distress, resting comfortably on physical exam
7. Document acuity and link conditions
    - Daily documentation of your patient's status along with rationale for your management and treatment
8. Avoid copy and pasting the same information each day – provide and update on conditions or note if they have resolved, or ruled out
9. Identify what is preventing transfer to a lower level of care or discharge
10. Document final status of differential diagnoses after final study

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