Best Practices in Clinical Record Keeping: Documenting the Diagnosis

Introduction

The clinical record must contain documentation of the physician's assessment of the member's condition that is being treated.

Documenting the Diagnosis

The diagnosis itself must be consistent with and supported by the member's presentation, examination, laboratory, and diagnostic imaging findings. Initially the diagnosis is often only the diagnostic impression or working diagnosis. On follow-up visits the diagnosis should be confirmed as the clinical thought process continues.

Documentation of return follow up visits (usually in the "A" portion of the SOAP note) must include a statement of the diagnosis that reflects changes in the member's condition as a response to time, treatment, and other interim events (e.g., "*Cervical strain, resolving"* or *"fatigue, improving*"). The "A" should be updated as necessary to be an accurate portrayal of the member's present condition.

Diagnosis codes used on a health insurance claim form must be supported by the information in the member clinical record.

ICD-10-CM

Transition to ICD-10-CM occurred October 1, 2015. The diagnosis codes in ICD-10 are more specific and more detailed. For example, left and right-side conditions (e.g., extremity conditions) are now 2 different diagnoses. And there are different diagnoses for certain conditions seen at an initial encounter, in follow up "subsequent" encounters and as a sequela. As with ICD-9 codes, the clinical record must support the code used to document the condition or as used on an insurance claim form.

Note: Some IH providers are prohibited by law from making a differential diagnosis and therefore, this "best practice" recommendation may not apply to all. However, many diagnosis codes are symptoms only and do not imply that the provider has made a "differential diagnosis." For example, "neck pain/cervicalgia" is M54.2 (ICD-10).