Documentation Best Practices
A Quick Reference Guide for Providers

Legibility
If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read.

Healthcare provider signature and credentials
Signatures must be clearly identified by a printed, legible provider name and credentials.

Abbreviations and Acronyms
Certain standard abbreviations and acronyms have multiple meanings; use industry-standard abbreviations and acronyms.

Consistency
Exercise caution when utilizing templates, copy-and-paste functions, carrying over diagnoses from a problems list, or electronic health records (EHRs) that could potentially introduce conflicting or contradictory information into your encounter note.

Confirmed vs. Uncertain
- Avoid the use of terms that imply uncertainty to describe diagnoses or conditions that are confirmed. In cases where the diagnosis is not confirmed, document only the signs and symptoms.
- E.g., "probable," "apparently," "likely," or "consistent with"

Supporting Documentation
- For chronic conditions that have an impact on patient care, treatment, and management but are being followed by a different healthcare provider.
- E.g., "Chronic obstructive pulmonary disease (COPD) followed by Dr. John Hancock, a pulmonologist."

Treatment Plan
- The current treatment plan for each diagnosis should be clearly documented and specific.
- If referrals or consultations are requested, the note should indicate to whom the referral or consultation is requested.
- Document all follow-up visits, even if on an as-needed basis only.

Problem Lists
- Problem lists should be reviewed at each visit to "resolve" conditions that no longer exist.
- All chronic conditions must be documented annually.

Each condition should be documented to the highest known level of specificity at the time of the visit.
Examples include severity, site, stage, laterality, episode, type, complications, comorbidities, and status (e.g. insulin, amputation).

Active vs. Historical
Update conditions to "history of" when they are no longer current but may affect treatment in the future.

Each encounter should be considered stand-alone
- All chronic conditions must be documented annually.
- Coders are not allowed to make assumptions to know the healthcare provider's intent.
- Industry-standard diagnosis coding guidelines require medical coders to apply a strict literal interpretation to the healthcare provider's medical record documentation.

Documentation should be clear and concise
- All conditions that coexist at the time of the visit requiring or affecting the management of care should be included.
- Establish medical necessity and clinical relevance during a visit.
- Clinical decision-making supports and validates each diagnosis in a face-to-face visit.
- Note all cause-and-effect relationships with managed conditions.

TAMPER
- **T**reat – prescribe or alter medications; initiate or adjust therapies; start other modalities
- **A**ssess – document current diagnosis; tests or diagnostic studies; discuss, counsel or advise
- **M**onitor – signs and symptoms; disease progression or regression
- **P**lan – document the future care
- **E**valuate – effectiveness of medications; response to treatment; test results
- **R**efer – to a specialist; follow-up

MEAT
- **M**onitor – signs/symptoms; surveillance of disease progression/regression (e.g. lab values)
- **E**valuate – current state of condition; medications; treatment outcomes; test results; lab work
- **A**ssess or address – order tests or lab work; discuss results; counsel; review records
- **T**reat – prescribe or alter medications; initiate therapies or diagnostic studies

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