Diagnosis Documentation and Coding Checklist

Be Specific	Document exact diagnosis (e.g., "Type 2 diabetes mellitus with and without complications (e.g., diabetic neuropathy)." Note severity or stage (mild, moderate, severe, acute, chronic)
Use Standardized Terminology	Use ICD-10-CM terms. Avoid unclear abbreviations; define if used, it could have multiple meanings Example: ✅"Acute Otitis Media" ❌"AOM" (unless defined)
Document Acute/ Complicating Conditions	Identify primary vs. secondary/comorbid diagnoses. (e.g., "COVID-19 (primary) with Severe persistent asthma (comorbidity) who develops pneumonia due to covid -19 (complication)." Include complications when present
Clarify Relationships	Document causal relationships between conditions if applicable. Example: "Diabetic hyper/hypoglycemia."
Collaborate & Clarify	Query unclear diagnoses with provider or CDI. Resolve uncertainties before coding
Avoid Unconfirmed Diagnoses	Code signs/symptoms only until a definitive diagnosis can be confirmed Example: Pt present with cough -Suspected bacterial pneumonia, pending cultures-Code cough only
Address Chronic Conditions	Document at each visit. Status of the condition; active, controlled, stable Treatment & Plan
Avoid Copy-Paste Errors	Update any copy/paste information to reflect the most current data
Timely & Accurate Entry	Document during or immediately after the encounter. Include date, time, and provider signature
Support With Clinical Evidence	Include relevant labs, imaging, procedures, or clinical findings. Example: "Centrilobular emphysema confirmed on CT scan."

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