

# Clinical Documentation Guidelines

CLINICAL DOCUMENTATION Directive 1173 Guidelines  
for Medical Record and Clinical Documentation Clinical  
Documentation Improvement Guidelines for Medical  
Record Documentation Ethical Standards for Clinical  
Documentation Improvement Bing: Clinical  
Documentation Guidelines Clinical Documentation and  
Coding: The Foundation of ICD-10-CM/PCS  
Documentation Tips - AHIMAVHA Handbook 1907.01,  
Health Information Management and Practice Brief:  
Evolving Roles in Clinical Documentation Clinical  
Documentation Standards Complying With Medical  
Record Documentation Requirements Insights and  
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Documentation and Coding: The Fine Brush Strokes  
Your Medical Documentation Matters - CMS Clinical  
Documentation Guidelines Clinical Practice Guidelines  
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Improvement - AAPC Clinical Documentation -  
American Psychiatric Association

## **CLINICAL DOCUMENTATION Directive 1173**

Clinical documentation is an important bridge between healthcare coders and physicians. It was developed to track a patient's condition and communicate the author's actions and thoughts to other members of the care team.

## **Guidelines for Medical Record and Clinical Documentation**

Health records must contain accurate information. Patients should answer all history questions in preparation for every medical encounter. Ancillary medical staff members should assist patients in authoring the history component of a medical encounter note in Medical providers should first read

## **Clinical Documentation Improvement**

Compliant clinical documentation and coding is essential to every healthcare setting, no matter the individual responsible for and/or performing the tasks. We need to ensure medical necessity is being met, of course, but not to a fault, whereby we are utilizing diagnoses only to obtain the coverage and medical necessity acceptance.

## **Guidelines for Medical Record Documentation**

Only factual notation about the incident along with clinical observations, including vital signs of the patient before and after the incident, clinical actions taken, and identification of any staff involved, must be documented in the patient health record. VHA HANDBOOK 1907.01 March 19, 2015.

## **Ethical Standards for Clinical Documentation Improvement**

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- Documentation should record both the actions taken by clinical staff and the patient's needs and/or their response to illness and the care they receive.
- Clinical staff have legislative, professional and ethical obligations to protect patient confidentiality.

### **Bing: Clinical Documentation Guidelines**

THIRD-PARTY ADDITIONAL DOCUMENTATION REQUESTS Upon request for a review, it is the billing provider's responsibility to obtain supporting documentation as needed from a referring physician's office (for example, physician order, notes to support medical necessity) or from an inpatient facility (for example, progress note).

### **Clinical Documentation and Coding: The Foundation of**

Clinical Documentation Standards This policy section defines the procedures and minimum standards for documentation of Medicare/Medi-Cal Specialty Mental Health Services at any site providing those services within Alameda County Behavioral Health Care Services and its Behavioral Health Plan's Provider Network.

### **ICD-10-CM/PCS Documentation Tips - AHIMA**

of clinical documentation improvement. This aspect of health care services not only includes coding and billing, but reaches beyond to include the

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documentation of quality of care. Clinical documentation improvement is a proactive measure. There must be consistency and attention to detail to improve clinical documentation. The focus of docu-

### **VHA Handbook 1907.01, Health Information Management and**

Perform concurrent reviews and offer providers feedback to improve completeness and specificity in documentation to Conduct chart reviews and any necessary provider education for compliance with quality reporting initiatives Perform retrospective chart reviews for coding compliance and quality

### **Practice Brief: Evolving Roles in Clinical Documentation**

by creating a large library of CDI ICD-10 documentation tips that are now available. for the healthcare industry. These tips focus on the language and/or wording that. will garnish greater details and specificity of the coded data for a given diagnosis, condition, disease and/or surgical procedure.

### **Clinical Documentation Standards**

1. Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality
2. Support the reporting of healthcare data elements (e.g. diagnoses and procedure codes, hospital acquired conditions,
3. Query the provider (physician or other qualified

## **Complying With Medical Record Documentation Requirements**

Clinical Documentation of a Telepsychiatry Encounter is as important as with any clinical encounter but there may be some important additional considerations including a special need for: Documentation of the time, date, remote site location

## **Insights and Best Practices for Clinical Documentation**

charting guides and norms that support clinical documentation. 1.2 All individuals shall adhere to all applicable clinical documentation requirements contained in: a) AHS policy; b) professional practice standards; c) ethical standards; d) accreditation standards; and e) legislation and regulations. 2. Clinical Documentation Principles

## **Clinical Documentation and Coding: The Fine Brush Strokes**

Guidelines for Medical Record Documentation 2 16. There is review for under - or overutilization of consultants. 17. If a consultation is requested, there a note from the consultant in the record. 18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review.

## **Your Medical Documentation Matters -**

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## **CMS**

Appropriate documentation provides an accurate reflection of nursing assessments, changes in clinical state, care provided and pertinent patient information to support the multidisciplinary team to deliver great care. Documentation provides evidence of care and is an important professional and medico legal requirement of nursing practice.

## **Clinical Documentation Guidelines**

Documentation is an important aspect of patient care and is used to:

- Coordinate services among medical professionals
- Furnish sufficient services
- Improve patient care
- Comply with regulations
- Support claims billed
- Reduce improper payments

## **Clinical Practice Guidelines | NCCIH**

The American Health Information Management Association (AHIMA) recently offered the following definition of clinical documentation improvement (CDI): “The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of inpatient health records for conflicting, incomplete, or nonspecific provider documentation.

## **Guidelines for Clinical Documentation Improvement - AAPC**

Clinical Practice Guidelines “Clinical practice guidelines are systematically developed statements

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to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” (Institute of Medicine, 1990)

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