Coding and Documentation Tips: History of

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It is the provider's responsibility to ensure what they are documenting about a patient's condition is thorough, complete, and concise. When a coder is reviewing the encounter note, all codes reported are based on what was documented by the provider.

Coders are not allowed to make assumptions when reviewing and coding a chart note. Due to this, some diagnoses can be missed, or miscoded.

One issue is when a provider documents a condition as ***"history of."***

- For many providers this means the diagnosis is **historical,** and the patient no longer has it.
- For other providers it means the patient has a history of the condition and **still is being treated** for it.

Example:

- HPI: Patient here for follow-up. He has a history of diabetes mellitus, stroke, hypertension.

Documentation such as this can be troublesome for a coder and, overall, in an audit. Unless any of those conditions are discussed in the same encounter, they may not be reportable.

A coder must keep the Official Coding Guidelines (OCG), Coding Clinic (CC), and any facility-specific coding guidelines in mind when auditing encounter notes. To code a diagnosis, the condition must be documented and there must be support for it.

Examples:

- M: Monitor - *Signs, symptoms, disease progression, disease regression*
- E: Evaluate - *Test results, medication effectiveness, response to treatment*
- A: Assess/Address - *Ordering tests, discussion, review records, counseling*
- T: Treat - *Medications, therapies, other modalities*

Due to these issues, it is important when documenting a patient's diagnoses to watch how "history of" is used.

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