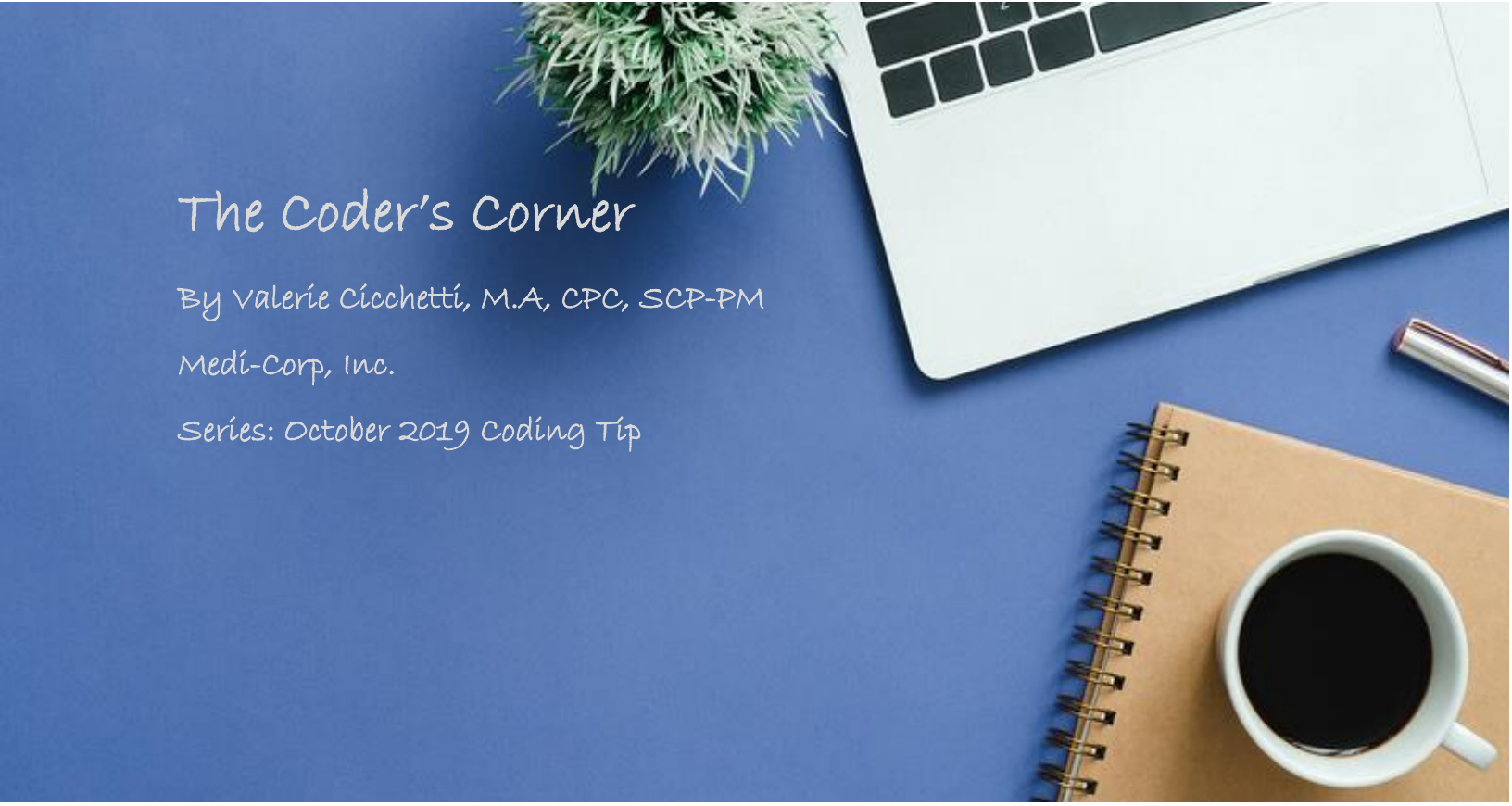

The Coder's Corner

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THE DO'S AND DO NOT'S FOR DOCUMENTING DIAGNOSIS

The Do's

- DO document pre-diagnosis (signs and symptoms)
- DO document abnormal test results
- DO document post-diagnosis (findings)
- DO document details such as, status and/or severity of chronic conditions
  - ***Type II DM w/hyperglycemia, Hypertensive Cardiomyopathy, Acute or Chronic Systolic Heart Failure***
- DO document to the highest degree of certainty for that encounter

The Do Not's

- DO NOT use uncertain wording for diagnosis
  - ***"Rule Out", "Probable", "Suspected", Likely", "Still to be Ruled Out", "Compatible With", etc.…***

- DO NOT leave the diagnosis undocumented or blank on the anesthesia record