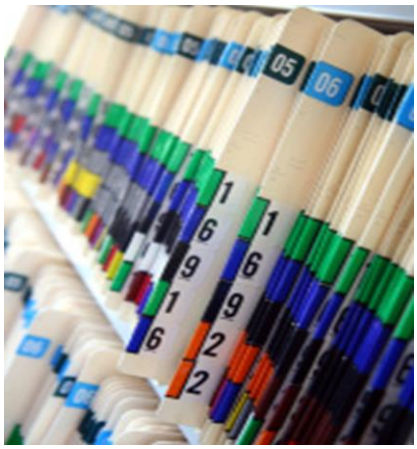
Molina Healthcare
Coding Education
How to ruin the perfect note?



Molina Healthcare is committed to supporting your clinical practice. Please take a moment to review these coding and documentation recommendations to enhance your knowledge. Documenting the clinical process through notes is the core of clinical work.

A progress note should:

- Be specific
- Contain a logical/evaluative statement
- Include a plan in a SOAP format

These features are consistent with CMS documentation standards.

Regarding Documentation

When documenting the care you provide it's important to be definitive and clear, recording accurately what you are seeing and treating. This facilitates understanding by others caring for the patient, and aids coders attempting to document the proper diagnosis codes. It's improper to use ambiguous statements or question marks in the assessment and plan. Avoid words that suggest that the clinician is uncertain what they are doing.

Examples of words to avoid include:

- **Borderline**
- **Rule-out**
- **Consider**
- **Possible**

Remember, "History of" before the diagnosis means the condition no longer exists.

When you use the word "Unchanged" in an evaluative statement, it requires the coder to compare a previous state or condition, which coders are not allowed to do. Instead, consider using "Controlled" or "Stable"

Have Questions?
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