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Recovery Auditor Protection II

Did you know this official coding guideline?

Different providers documenting in the same medical record may not conflict as to which terminology they label a particular diagnosis

Examples of **conflicting documentation**:

1. Hospitalist #1 documents "acute renal failure", but the following day, Hospitalist #2 documents "acute renal insufficiency".
   - If "acute renal insufficiency" is documented through the remainder of the chart and into the discharge summary, the hospital will not be able to code "acute renal failure".
2. The hospitalist documents "delirium", but the neurologist documents "acute encephalopathy".
   - If the hospitalist continues to document "delirium" through the remainder of the chart and into the discharge summary, the hospital will not be able to code "acute encephalopathy".

If either of these situations occurs, the patient will appear to have a lower severity of illness (SOI) than would have been portrayed if the more specific terms, i.e. "acute renal failure" or "acute encephalopathy" were consistently used.

- **Don't downgrade diagnoses written by previous providers – *auditors love it when you do this!***
- **Adopt the more specific terminology provided by your consultants when you ask them to evaluate or manage a particular problem.**