**Appropriate Medical Diagnosis**

# Date Implemented:

**Review/Update Dates:**

# Policy

In accordance with clinical standards of practice **[Enter Provider Name]** will ensure that all residents receive appropriate medical diagnoses supported by clinical documentation included in the resident’s medical record.

# Purpose

Inappropriate diagnoses may lead to unnecessary medication and treatment for the residents as well as penalties for potentially falsifying medical records for staff. **[Enter Provider Name]** will ensure that there is appropriate supporting documentation to justify including a diagnosis in the resident’s record.

**Definitions:**

**Professional standards of quality** mean that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired outcomes may also be found in clinical literature.

**Procedures**

**[Enter Provider Name]** prior to admission, available resident’s records will be reviewed for medical diagnoses. Based on diagnoses included in pre-admission records, staff will ensure that supporting documentation is present in the nursing home record to justify appropriate diagnoses are included in the nursing homes medical record.

The Centers for Medicare & Medicaid Services (CMS) provides the following examples of when a diagnosis may not be adequately supported by clinical documentation:

* A diagnosis that is only mentioned as an indication for medication administration without supporting documentation such as a diagnosis of diabetes without an A1C level supporting the diagnosis.
* The addition of, or request by the staff at the nursing home to the physician for a diagnosis without supporting evidence such as a fax requesting a diagnosis of depression because the resident is taking an antidepressant. However, the documentation provided does not indicate that the resident was evaluated for depression.
* A practitioner’s note or transfer summary from a previous provided stating a “history of” without supporting documentation confirming the diagnosis with a previous practitioner or family and there was a lack of evidence that the practitioner completed a comprehensive evaluation after admission.
* A diagnosis list that lacks supporting documentation.
* A diagnosis that pre-populated from electronic health record interoperability such as when the nursing home medical record platform is connected to a hospital or clinical based system that pre-populates information.
* A note of diagnosis in the medical record by a nurse without supporting documentation.

It is essential that staff complete a thorough investigation of diagnoses included in the medical record which may include contacting previous providers, obtain supporting laboratory or diagnostic results, and/or contacting specialists for evaluation notes.

If the nursing home staff are unable to obtain supporting documentation for an identified diagnosis, the diagnosis will be removed from the medical record. Staff will consult with the residents’ primary physician to determine if continued medication administration and/or treatments are necessary. This may include tapering medications prior to discontinuation for the safety of the individual.

**[Enter Provider Name]** will not code diagnoses on the minimum data set (MDS) without appropriate supporting documentation. According to the State Operations Manual for the Requirements of Participation in Medicare and Medicaid, individuals knowingly including documentation without adequate supporting documentation may be referred to the state licensing board(s) and the Office of Inspector General (OIG) and face criminal and/or civil penalties.

If there is question on what supporting evidence is necessary to justify a diagnosis, the staff member shall review appropriate materials that identify the standards of practice such as clinical textbooks, professional publications in credible sources, and/or professional association information such as the American Medical Association. If a diagnosis needs to be removed from the resident’s medical record, **[Enter Provider Name]** will consult with the resident’s physician to determine if it is appropriate to remove the diagnosis based on a lack of supporting documentation.

If there are concerns with particular physicians including diagnoses that do not have sufficient supporting evidence, **[Enter Provider Name]** will discuss with the particular physician their concerns. If there are additional concerns identified, **[Enter Provider Name]** will consult with the medical director. The medical director will take appropriate action such as meeting with the particular physician to discuss concerns. Ongoing concerns not corrected when addressed may be reported to the appropriate professional board as determined appropriate.

**Resources**

CMS. (18 Nov. 2024). *Revised Long-Term Care (LTC) Surveyor Guidance: Significant Revisions to Enhance Quality of Oversights of the LTC Survey Process or QSO-25-07-NH*. <https://www.cms.gov/files/document/revised-long-term-care-ltc-surveyor-guidance-significant-revisions-enhance-quality-and-oversights-ltc.pdf>