# Diagnosis & Problem List Update Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

**A diagnosis and problem list update** is the dated, authored entry a clinician makes when adding, refining, correcting, or resolving a diagnosis in the medical record, including the ICD-10-CM code that flows onto claims. Clinicians, coders, and CDI teams use it whenever the active diagnosis list changes. Most entries run 50 to 200 words: a diagnostic statement plus the clinical support for it.

**Entry header and type** label the change first
**Do:** date, author with credentials, and the entry type: new, refinement, correction, delayed, status change, or resolution.
**Pitfall:** editing an earlier note in place; the audit trail shows it, and an unlabeled alteration reads as concealment.

**Diagnostic statement** with severity, episode, course
**Do:** the diagnosis in your words; ICD-10-CM Guideline I.A.19 bases code assignment on this statement, not the picklist.
**Pitfall:** a code with no statement behind it gives a coder nothing to assign from and an auditor nothing to verify.

**Onset, status, and rule-outs** answer open questions
**Do:** when it began or was established; active, improving, in remission, or resolved; any rule-outs still pending.
**Pitfall:** rule-out language left until it hardens into the diagnosis; the record should show when it was answered.

**Clinical support at this encounter** same-day evidence
**Do:** for any diagnosis on the day's claim, evidence it was monitored, evaluated, assessed, or treated today.
**Pitfall:** the copied-forward chronic condition; past conditions reported as current is the root cause OIG cites in audits.

**Coding mapping** specificity decides necessity and risk adjustment
**Do:** the ICD-10-CM code, the code it replaces, and effective dates; DSM-5-TR labels map to ICD-10-CM on the claim.
**Pitfall:** an unspecified code such as F41.9 kept after the documentation already supports a more specific one.

**Problem list action** current and active only
**Do:** added, status changed, resolved with a date, or moved to history with the applicable Z-code.
**Pitfall:** history-of used as a parking space; a resolved condition leaves the list or becomes a history code, not current.

**Attestation** at or near the time
**Do:** signature, credentials, and date at or near the time of the change; originals stay readable when correcting.
**Pitfall:** amending at audit time; RADV guidance treats a record amended when the auditor calls as untimely outright.

## Before you sign

- [ ] Entry labeled by type, dated, and authored with credentials
- [ ] Statement in your words, with specifiers, carries the code
- [ ] Original entries preserved and readable, never overwritten
- [ ] Same-day support for every diagnosis on today's claim
- [ ] Resolved conditions dated, off the active list or to a Z-code
- [ ] Signed with credentials at the time of the change

## Drafting with AI

Bring the prior diagnosis with its date and code, today's scores or findings, and the change you intend; the structure mirrors what coders and auditors check.

> *"Draft a problem list update: GAD criteria now met, GAD-7 14 today, refine the intake unspecified anxiety code, resolve the adjustment disorder: ..."*

**Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a BAA on every plan.**

| 50 to 200 words | 3 to 8 min by hand | When the list changes | Coders · payers · auditors |
|---|---|---|---|
| statement plus support | clinical team estimate | add, refine, correct, resolve | who reads it |

Full guide, sample entry, and compliance notes:
**bastiongpt.com/template/diagnosis-list-update**

# Diagnosis & Problem List Update Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient / client: DOB: Date of entry:

Author (name, credentials): Linked encounter date:

**Entry type**

☐ new diagnosis ☐ refinement (specificity) ☐ correction / amendment
☐ delayed entry ☐ status change ☐ resolution

**Diagnostic statement**

Your words, with severity, episode, and course specifiers · the code is assigned from this statement

Onset / established: Status (active / improving / in remission / resolved):

Rule-outs pending:

**Clinical support at this encounter**

Monitored, evaluated, assessed, or treated today · shown by a score, an exam finding, or a medication decision

**Coding mapping**

New or confirmed code: Replaces: Effective date:

DSM-5-TR label (if used): Claim affected: ☐ yes ☐ no

**Problem list action**

☐ added ☐ status updated ☐ resolved (date: _____ )
☐ moved to history (Z-code: _____ )
If correcting a prior entry: original preserved and identified ☐

Signature / credentials: Date / time: