Debra D. Sullivan

GUIDE TO Clinical Documentation

THIRD EDITION

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Clinical Documentation

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Dedication

When I think back to 2004, when the first edition of this book was published, I think of a wonderful group of friends who were there to celebrate with me. As I anticipate the publication of the third edition, almost all of those same wonderful friends are still here, encouraging and supporting me, and cheering me on to the finish line. Sadly, my dear friend Candy left us much too soon, and I miss her sweet presence more than words can say. The essence of her heart and soul is with me always. For the remaining STUB-C friends (Kent, Donna, Paige, Jeff, John, Brianna, Justin, Tim, Carla, and Jeff), thanks for your friendship, your love, and your constancy in my life through the past two decades. I couldn't ask for a better group of people to share life with! I hope there are many more decades to come!

Not only have I been blessed with these incredible friends, but I am fortunate to have the most loving, caring, and supportive husband any woman could hope for. Greg is an unwavering source of encouragement and inspires and challenges me to be the best I can be. He has stood beside me without complaint through the days of writer's block, looming deadlines, malfunctioning computers, and the often-self-imposed frenzy of my world. He has the insight to know when to cheer me on, when to make me take a break, and when to give me space. I am so grateful for his calming influence, his ability to make me laugh and not take myself too seriously, and all he does to keep things running smoothly in the Sullivan household. Thanks, Greg, for all this, and so much more. And I promise… no fourth edition!

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Acknowledgments

It is interesting to me how each edition of this book has its own uniqueness. I have worked at a different place during the writing of each edition, and I hope that has resulted in a deep layering of experience and knowledge that makes each edition better. I certainly feel like each job change has enhanced my professional practice and has enriched me as a person. I have met and worked with some extraordinary health-care providers, and I have had valuable contributions from so many of them.

First, I would like to say thank you to my colleagues at Academic Urology and Urogynecology of Arizona. I have had such encouragement and support from this great group of people. I am grateful to have learned from so many outstanding health-care providers throughout my more than 27 years in medicine. I have benefitted from the expertise of Jamie Bair, NP (cardiology); Jennifer Nelson, PA-C (psychiatry); Steve Turner, RN (hospice); Dr. Richard Guthrie (palliative care); and several outstanding hospitalists who wished to remain nameless. I'm thankful for a group of dedicated Information Technology people who have helped me navigate electronic medical records and who've answered my questions with enthusiasm.

I must take this opportunity to acknowledge two incredible women who added so much to the Document Library that we included in this edition of the book: Madison Palmer, MMS, PA-C, not only contributed the prenatal records, but she also provided valuable assistance with content in the prenatal chapter. Larissa J. Bech, MSN, RN, FNP-C contributed the pediatric records. Without their contributions, the prenatal and pediatric visit notes would not exist. They bring real-world knowledge and hands-on patient care experience where I would only have been able to read and write about what others do.

There is a tremendous team of people at F. A. Davis who have been part of this project. Even though he retired before this edition was published, my dear friend Andy McPhee was the driving (cajoling? bullying?) force behind the third edition. I hope he is enjoying his much-deserved retirement and getting to write what he wants, when he wants, if he wants. When Andy approached me about a third edition, one of the most anxiety-producing aspects of considering it was who would be the developmental editor because I had less-than-wonderful experiences on the two previous editions. I need not have worried at all, as I have had the very good fortune to work with Stephanie Kelly, developmental editor extraordinaire! Stephanie's knowledge of the process, her organizational skills, her sense of humor, and her hard work have made the journey so enjoyable, and she has my deepest gratitude. I'm also grateful for the guidance of and contributions from Melissa Duffield, Senior Acquisitions Editor; George Lang, Director of Content Development; Amelia Blevins, Developmental Editor for Digital Products; Megan Suermann, Content Project Manager; Lori Bradshaw, Developmental Production Editor at S4Carlisle Publishing; and Robert Butler, Production Manager. There's probably not another publishing company around that would have supported this project as F. A. Davis has done, and I'm humbled and honored they chose to champion this book.

—Debbie Sullivan

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Introduction

It's no secret that medicine is constantly changing and evolving, but I guess I didn't realize that there have been so many changes and evolutions in *documentation* until I started working on the third edition. Since the second edition was published in 2011, there have been significant changes in coding, billing, reimbursable services, federal requirements for documentation, platforms for documentation, and so on. And, thanks to the feedback from users of this text and thoughtful reviews by educators and practitioners, the "wish list" of content for this text has changed as well. So, here you have it, the third—and by far, the best—edition. One thing that has not changed is the basic principle of the book—this is an instructional work on *documentation* and is not meant to be an instructional work on the practice of medicine. Documentation and the practice of medicine are interrelated, and it is sometimes a challenge to keep them separate. However, they are two distinctly different practices. As an educator, I teach. As a Physician Assistant, I practice medicine. As an author, sometimes I want to do both, but that has never been the goal. The goal is to provide a solid foundation of principles of documentation that will preserve important aspects of the health-care provider–patient encounter while meeting the requirements for reimbursement and other regulations. There are many examples of documentation of various encounters throughout this book, and each *is just one example* of how an encounter may be documented. There is not just one way to document any encounter but many different ways; and different doesn't mean "good" and "bad"—just different. I'm of the opinion that the more examples you see, the more you will learn and the more prepared you will be when it comes time for you to document your way.

Revisions started with the Table of Contents, which has been expanded to highlight sections within the chapters and to provide much more detail about the content. New content includes Chapter 4, Documenting Prenatal Care and Perinatal Events, and Chapter 7, Older Adult Preventive Care Visits. Some chapters were relocated within the text to present a more chronological sequence. Every chapter was revised; some revisions were fairly minor, whereas others were extensive. Medicolegal Alerts are included in each chapter to help highlight important concepts. New to this edition are images of electronic medical record (EMR) entries, or screen shots. There are multiple EMR systems available, so what is presented may look different from what you've seen before, but I think it is helpful to see sample entries from different systems.

Sometimes Appendices don't get a lot of attention, but I hope you'll check out Appendix A, the Document Library. In the library, you'll find documents that pertain to a particular patient grouped together in a way that captures the patient's care chronologically. This provides a different perspective than seeing them as "stand-alone" documents in multiple chapters.

Many educators mentioned that they would like the worksheet answers moved out of the book so that they could be used more effectively as an educational tool, so this was done. You can find them in the Instructor's Guide, at DavisPlus on the F.A. Davis website, which will allow you to provide them to the students as you see fit—you can simply provide the answers so students can check their own work, or you can use the worksheets as graded assignments.

Whether you are a student, a novice practitioner, or an experienced provider, I hope this book will be a valuable resource in your journey of professional development.

—Debbie Sullivan
Phoenix, Arizona

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Chapter 1

Medicolegal Principles of Documentation

LEARNING OUTCOMES

- Discuss medical and legal considerations of documentation.
- Identify groups of people who may access medical records.
- Identify general principles of documentation.
- Discuss medical coding and billing.
- Define the terms *electronic medical records, meaningful use,* and *interoperability.*
- Identify benefits of using electronic medical records.
- Identify challenges and barriers to using electronic medical records.
- Identify components of the Health Insurance Portability and Accountability Act.
- Discuss principles of confidentiality.

Introduction

You might be asking, "Why a book on documentation?" Documentation is one of the most important skills a health-care provider can learn. You might feel tempted to focus considerably more time and energy on learning other skills, such as physical examination, suturing, or pharmacotherapeutics. These are essential skills, but documentation is likewise extremely important. State licensure laws and regulations, accrediting bodies, professional organizations, and federal reimbursement programs all require that health-care providers maintain a record for each of their patients.

Documentation used to be mostly a memory aid for the provider—a quick note of his or her thoughts about a patient's presentation, a likely diagnosis, maybe a few words about the treatment plan. Over the past few decades, however, documentation has become a more complex task due to changes in medicine and with patients themselves. Increased complexity in the medical field is evident by the ever-increasing number of medications and treatment modalities available to health-care providers. In addition, patients live longer with a greater number of comorbid conditions, adding to the complexity of caring for them and requiring that complexity in the medical records. The fact that our society is so litigious certainly adds more weight to clinical documentation and puts a greater burden on providers to capture their thoughts and actions for others to read and interpret years after an episode of care took place.

Dr. Mitchell Cohen wrote about this evolution of documentation in an article that appeared in *Family Practice Management*.* Dr. Cohen explains:

> *From time to time I'll stumble upon an old chart in my office that goes back 40 years. My predecessors charted office visits on sheets of lined manila card stock, which would suffice for at least 15 to 20 visits. Clearly, these charts were only intended for the physicians as a way to refresh their memory of what happened from one visit to the next. For example, the documentation for one visit read simply, "1/20/67: pharyngitis >> penicillin." These days chart notes are primarily not for the physician or patient, but for all the others who aren't in the exam room and yet feel they have a stake in what takes place in this once confidential arena. To satisfy coders and insurers, my documentation for a 99213 sore throat visit must contain one to three elements of the history of present illness, a pertinent review of systems, six to 11 elements of the physical exam, and low-complexity medical decision-making. My malpractice carrier and my future defense attorney would also like me to explain my clinical rationale for why the patient has strep throat and not a retropharyngeal abscess or meningitis. A table with a McIsaac score calculating the likelihood that this*

patient does indeed have strep throat might be nice as well. If I prescribe a weak narcotic for a really nasty case of strep, the state medical board would be pleased if I addressed what other medications have been tried and whether the patient has any history of addiction. I'll also need to document that I explained the proper use of the medications and the need for follow up if the patient doesn't get better. When I'm finally done with my note, it looks like this:

CC: sore throat x 2d
HPI: 17 y/o F with 2d h/o sore throat. Has an associated headache and fever to 101°F. No significant cough. Patient has noticed some swollen lumps in neck. Having significant pain despite use of Tylenol, ibuprofen and salt water gargles.
Social Hx: no h/o substance abuse or addiction.
ROS: denies neck stiffness or back pain, no rash. No difficulty speaking.
PE: VS: AF, VSS
Gen: alert, pleasant female in NAD
HEENT: NC/AT, PERRLA, EOMI, TM clear b/l, OP notable for tonsillar enlargement with exudates. No asymmetry or uvular deviation present.
Neck: + tender anterior cervical adenopathy, no nuchal rigidity or meningismus.
CV: RRR S1/S2 without murmurs.
C/L: CTAB
Abd: soft, nondistended, nontender, no hepatosplenomegaly.
McIsaac's score = 4; Rapid strep +
A: streptococcal pharyngitis
P: 1) Pen VK 500 mg po TID x 10 days. Discussed risks of medication including allergic reaction and complications of not taking full course of antibiotics including rheumatic fever and valvular heart disease.
2) hydrocodone elixir q HS to help relieve pain particularly when trying to rest. Has already tried acetaminophen and NSAID and will continue salt water gargles. Follow up if no improvement in one week. Have discussed other potential diagnoses and reviewed warning signs of retropharyngeal abscess and meningitis. Patient agrees and understands plan.

Like I said, "pharyngitis >> penicillin."
*(*Used with permission of the American Academy of Family Physicians)*

Medical Considerations of Documentation

As illustrated in the example, the medical record serves to document the details of the patient's complaint and the medical evaluation and treatment. The medical record also serves other purposes and has audiences other than the patient and the health-care provider; it is both a *medical* and a *legal* document. The medical record establishes your credibility as a health-care provider. It is important to remember that you are creating a record that other professionals will read; therefore, you should use professional language and include appropriate content. Other readers will assume, rightly or wrongly, that you practice medicine in much the same way that you document. If your documentation is sloppy, full of errors, or incomplete, others will assume that is the way you practice. Conversely, thorough, legible, and complete documentation will infer that you provide care in the same way, thus establishing your credibility. Some excellent providers simply do not have good documentation skills. However, this is the exception rather than the rule. It is very difficult to persuade those who read sloppy documentation that the person who wrote that way can, and did, provide good care.

Up-to-date and complete documentation is an essential component of quality patient care. The medical record is the primary means of communication between members of the health-care team and facilitates continuity of care and communication among the professionals involved in a patient's care. Although many patients will have a primary care provider who provides most of their care, patients also may see specialists for specific problems. Medical records are the vehicle for communication among members of the health-care team, and the medical record is the common storehouse for all information about the patient's care and condition regardless of who is providing that care.

Legal Considerations of Documentation

As mentioned previously, all medical records are legal documents and are important for both the health-care provider and the patient, regardless of where the patient care takes place. The most important legal functions of medical records are to provide evidence that appropriate care was given and to document the patient's response to that care. An often-quoted principle of documentation, which every health-care provider has probably heard, is that if it is not documented, it was not done. This is a fallacy because it is impossible to capture with documentation every nuance of a patient–provider encounter, and it is impossible to create a perfect record of every encounter. However, the principle behind the quote is important in a legal context; there is a considerable time lapse between when events occur (and are documented) and when litigation occurs. It may be anywhere from

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2 to 7 years from the occurrence of an event until you are called to give a sworn account of the event. The medical record is usually the only detailed record of what actually occurred, and only what is written is considered to have occurred. You will not remember the details of an event that happened 6 years ago; your only memory aid will be the medical record. As a legal document, the medical record that you authored will be made available to plaintiff attorneys, defense attorneys, malpractice carriers, jurors, judges, and, most likely, the patient. You should keep this in mind at all times when documenting.

The record should be objective. Personal, subjective opinions regarding the patient, the patient's family, or other providers do not belong in the medical record. It is human nature to make value judgments about others, but it is asking for trouble to note in a record those irrelevant judgments about the patient. Document facts; not opinions. All providers should strive for accuracy in documentation. Correcting a medical record is not only encouraged, but it is necessary in order to avoid potentially harmful mistakes or misrepresentations. Altering a record should never be done. *Alteration* connotes an improper change, concealment, or omission of portions of records that were written inappropriately. *Correction* implies the act of making something right. Record alterations have rendered many defensible cases indefensible. Most jurors will suspect that a provider who alters records has done so to cover up a mistake. The opposing attorney will argue that alteration shows consciousness of guilt. Alterations in medical records may give rise to a claim for punitive damages against a provider. Intentionally altering or destroying a patient's chart is considered unprofessional conduct. Most states will consider a practitioner who alters or destroys a patient's chart to have violated the applicable licensing statute and will sanction or suspend the practitioner's license to practice medicine.

Other Purposes of Documentation

Reviewers from various organizations can obtain access to a medical record for a variety of purposes. Health-care payers require reasonable documentation for a number of reasons:

- To ensure that a service is consistent with the patient's insurance coverage
- To validate the site of service, medical necessity, and appropriateness of the diagnostic and/or therapeutic services provided
- To confirm that services furnished were accurately reported

Clear and concise documentation is required to receive accurate and timely payment for furnished services. Peer-review organizations might read the record to determine whether the care reflected in your documentation is consistent with the standard of care. Researchers often obtain access to medical records for purposes of conducting scientific studies. Although it is important to remember that these audiences may have access to your records, you should keep in mind that the primary audience of the medical records will be medical professionals involved in direct patient care.

Throughout this book, you will analyze examples of documentation. You may also complete the worksheets, which will help you apply the information as you read it. The purpose of this book is to teach documentation skills and critical analysis of medical records, not to instruct on the practice of medicine or to teach medical decision-making. The content of a medical record—or learning *what* to document—varies greatly, depending on the patient's presenting problem or condition. The principles of *how* to document and *why* documentation is important do not vary as much and, thus, are the focus throughout this book.

General Principles of Documentation

The Centers for Medicare and Medicaid Services (CMS) is one agency of the U.S. Department of Health and Human Services (HHS). As one of the nation's largest payers for health-care services, CMS has established specific guidelines for documentation that are referenced several times throughout this book. There are two sets of documentation guidelines currently in use: the 1995 and the 1997 guidelines. CMS published an evaluation and management guide in 2015; however, it was offered as a reference tool and did not replace the content found in the 1995 and 1997 guidelines. There are minor differences between the two guidelines, and it is recommended that health-care providers refer to the guidelines to identify those differences. Additional information may be found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf.

Both sets of guidelines recognize the following general principles of documentation:

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include the following:
   - Reason for the encounter and relevant history, physical examination findings, and diagnostic test results

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- Assessment, clinical impression, or diagnosis
- Plan for care
- Date and legible identity of the health-care provider

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and consulting providers.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnoses should be documented.
7. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical records. (More discussion of billing and coding is included later in this chapter.)

There are other generally accepted principles of documentation, such as that each entry should include the date and time the record was created and should identify the person creating the record. In settings in which care is provided around the clock, military time is often used to avoid confusion between a.m. and p.m. One o'clock in the afternoon is 1300, 10:30 at night is 2230, and so forth. Electronic medical record (EMR) systems create a "digital footprint" every time a record is accessed. This digital footprint includes the date and time and the identity (typically name and title and/or role) of the person accessing the record. The system also will indicate the time and date of any updates or changes made to the record. You should never document in a patient's record in advance of seeing the patient. In addition, you can correct or amend a patient's medical record, but you should never alter it. At times, it will be necessary to make corrections to a record. When making a correction in a paper record, you should draw a single line through the text that is erroneous, initial and date the entry, and label it as an error. If there is room, you may enter the correct text in the same area of the note. You should not write in the margins of a page; if there is no room to enter the correct text, use an addendum to record the information. You should never obliterate an original note, nor should you use correction fluid or tape. In the EMR, once a document is submitted, it is still possible to modify or correct the record. If an entire entry is incorrect (for example, charting on the wrong patient), there is a process to identify the entry as an erroneous document. The process will vary with different EMR systems, and institutions will have their own policy for identifying erroneous entries.

Based on your reading, complete the application exercise that follows.

Application Exercise 1.1

After seeing patient E. H. and documenting the encounter, you realize that you previously entered medications and allergies for another patient in E. H.'s chart. Correct the record to show the correct medications as follows: Zocor 20 mg daily, metformin 500 mg daily, Synthroid 0.125 mg daily.

PMH: E. H. has a history of type 2 diabetes (diagnosed at age 41), hypothyroidism (diagnosed at age 37), and hyperlipidemia (diagnosed at age 39). Surgical history includes tonsillectomy as a child and cholecystectomy at age 42. Medications include Lasix 20 mg daily, Diovan 80 mg daily, warfarin 5 mg daily, and vitamin D, 2 capsules daily. Allergic to sulfa drugs. Family history is positive for diabetes in mother and maternal grandmother and heart disease in paternal grandfather.

Application Exercise 1.1 Answer

PMH: E. H. has a history of type 2 diabetes (diagnosed at age 41); hypothyroidism (diagnosed at age 37), and hyperlipidemia (diagnosed at age 39). Surgical history includes tonsillectomy as a child and cholecystectomy at age 42. Medications include

error ds 5/7/18 Zocor 20 mg daily, metformin 500 mg daily, Synthroid 0.125 mg daily.

~~Lasix 20 mg daily, Diovan 80 mg daily, Warfarin 5 mg daily, and vitamin D, 2 capsules daily~~. Allergic to sulfa drugs.

Family history is positive for diabetes in mother and maternal grandmother, and heart disease in paternal grandfather.

If using a ruled sheet such as an order sheet or progress note, be sure that there are no blank lines. If a record is dictated and then transcribed, read the transcription before signing it, correcting any errors in the process. You should not stamp a record "signed but not read" or "dictated but not reviewed" because doing so will call attention to the fact that you did not verify the content of the record.

When entering the medical field, you must learn the language in order to function. Part of learning this language

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is to learn the meaning of the abbreviations, acronyms, and symbols in use; therefore, they are incorporated in this text. Abbreviations are a convenience, a time saver, a space saver, and a way of avoiding the possibility of misspelled words. Incorporating abbreviations is not an endorsement of their legitimacy, but it is intended to assist individuals in reading and understanding medically related documents. Sometimes abbreviations are not understood. They can be misread or interpreted incorrectly. For example, the abbreviation "CP" could mean "chest pain" or "cerebral palsy." Of course, the rest of the entry should make clear the term for which the abbreviation is being used. There are variations in how an abbreviation can be expressed. "Anterior-posterior" has been written as *AP, A.P., A/P.* Abbreviations may appear as all uppercase or all lowercase, and they may or may not have periods after each letter (for example, *PRN, prn, P.R.N.,* meaning "as needed"). Many inherent problems associated with abbreviations contribute to or cause errors. Health-care organizations should formulate a "Do Not Use" list of dangerous abbreviations, and you as the health-care provider are responsible for complying with your institution's policies regarding use of abbreviations.

Medical Coding and Billing

Concise documentation of the medical encounter is critical to providing patients with quality care and to ensuring accurate and timely reimbursement. Medical records are subject to review by payers to validate that the services provided were medically necessary and were consistent with the individual's insurance coverage. Standard codes are assigned to reflect the health-care diagnosis, procedures, and medical services provided and to create a uniform vocabulary for claims processing, medical care review, medical education, and research. Two important code sets are the Current Procedure Terminology (CPT) and the International Classification of Diseases (ICD) codes. CPT codes are used to document many of the medical procedures performed in a physician's office. This code set is published and maintained by the American Medical Association (AMA). CPT codes are five-digit numeric codes that are divided into three categories. The first category is used most often, and it is divided into six ranges that correspond to six major medical fields: Evaluation and Management (E/M; discussed in more detail next), Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. The second category of CPT codes corresponds to performance measurement and, in some cases, laboratory or radiology test results. Typically, these five-digit, alphanumeric codes are added to the end of a Category I CPT code with a hyphen. The third category of CPT codes corresponds to emerging medical technology. There are approximately 7,800 CPT codes, and the codes are updated annually.

Evaluation and Management Services

When a patient presents for care, you as the health-care provider evaluate the patient and then proceed to manage the presenting complaint. That encounter between you and the patient may vary from brief to comprehensive depending on the patient's chief complaint. For example, the time required for evaluation of a child who presents with a sore throat is typically brief, and the management options are fairly straightforward. Conversely, more time is required for evaluating an older adult who has several chronic conditions and a new complaint of chest pain, and the evaluation and management process is more complex.

CPT codes assigned for E/M services are determined by several factors. One factor is whether the patient is new, established, or seen for consultation services, and another is the setting where care is provided. Complexity of service is another factor and is determined by three key elements: history (including history of present illness [HPI]; review of systems [ROS]; and past medical, family, and social history [PMFSH], which are explored in Chapter 2), physical examination, and medical decision-making. The complexity considers the presenting complaint, co-existing medical problems, amount of data to be reviewed (i.e., tests and old records), amount of time that you spend with the patient, number of diagnoses and treatment options, and risk for significant complications. Table 1-1 summarizes the requirements for each level of E/M based on history, physical examination, and complexity of medical decision-making. In the case where counseling and/or coordination of care constitutes more than 50% of the encounter, time is considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of or decision-making for the patient. If you elect to report the level of service based on counseling and/or coordination of care, then you would document the total length of time of the encounter, and you should describe in the record the counseling and/or activities performed to coordinate care. Counseling includes discussion of diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management options; instructions for management and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education. An example of documentation of time spent with a patient is shown in Example 1.1.

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