2015 New Resident Documentation

WVUPC

Laura Sullivan, MSW, CPC

WVU Physicians of Charleston

Legal Stuff

The information provided here is personal opinion only and should not be construed as legal advice. Each provider is ultimately responsible for bills submitted under their NPI numbers. For specific legal guidance on any billing issue, consult with your Medicare Carrier and/or your health care attorney.

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Signature

- Sign each note legibly (no initials)
- Add pager number to signature
- Date each note clearly (time as necessary)
- Sign each note as you did the signature log

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Chief Complaint

Each note must have a Chief Complaint (CC) this must have the reason that the patient is being seen.

Ask yourself **WHY?** am I seeing this patient.

CC: “no problems or complaints” is unacceptable.

CC: “no new complaints” no further complaints”

acceptable but not ideal

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Chief Complaint Examples

Office Examples

CC: Annual physical

CC: Pap & Pelvic

CC: follow up for PNA

CC: HTN & DM

Hospital Examples

CC: No changes still SOB

CC: Pt has no complaints still following BP….

CC: Sugar still elevated….

The following was an actual inpatient chief complaint

CC: No further episodes of breathing

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History of Present Illness (HPI)

Document at least 4 of the following

Location
Quality
Severity
Duration
Timing

Modifying factors
Associated signs or symptoms
Context

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Past, Family & Social History (PFSH)

One element of each should be noted:

Example 1:

Past: No surgeries

Family: mother has DMII

Social: Married no children

Example 2:

PFSH: Patient poor historian, no family present to assist

Example 3:

Past: Gallbladder removed 2008

Family: no known problems

Social: Non Smoker

Example 4:

PFSH: Patient intubated and unresponsive unable to obtain

Non-contributory is unacceptable for any PFSH components

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Review of Systems (ROS)

ROS is a review of SYMPTOMS not illnesses or conditions.

HTN or DMII are not symptoms

Constipation, headaches, sweating, difficulty sleeping, short of breath, arm pain, swelling in toe are just a few examples of an ROS

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Review of systems

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- GI
- GU

- Musculoskeletal
- Integumentary
- Neurological
- Psychological
- Endocrine
- Hem/Lymph
- Allergy/Immuno

List at lease 2 positives and then you can state
"all other systems negative" (if they are)

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Unobtainable History

If you are unable to obtain a history due to the patient's condition the following must be documented:

- Medical reason (not "on vent")
  - "sedated on vent"
  - "unable to speak due to ….."
- That the family wasn't present
  - If partial history is obtain from family members that should be documented clearly
- Previous records
  - Previous records should be reviewed for history, if not available chart should be noted

"unable to obtain history, pt is sedated on vent, no family present, no previous records available"

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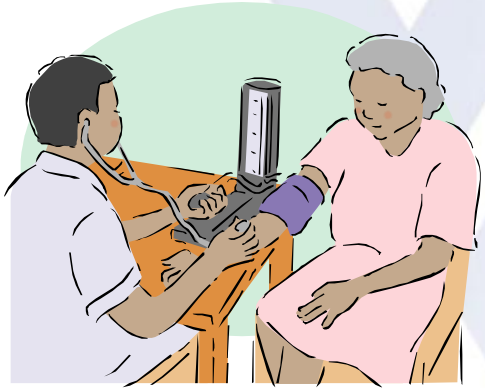
Examination Areas

- Constitutional (vitals etc)
- Eyes
- Ears, nose, throat, mouth
- CV
- Resp
- GI
- GU



- Musculoskeletal
- Skin
- Neurological
- Psychological
- Hem/lymph/Immuno

Must document at least 8 areas for a complete exam

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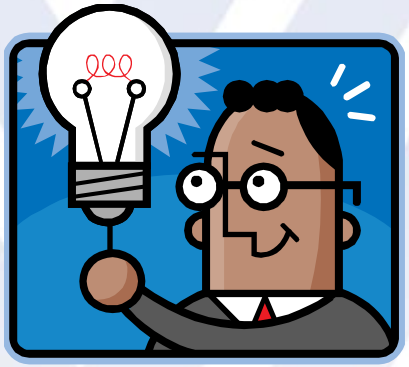
Assessment & Plan

1. Documentation should include the condition or symptoms being treated
2. Labs & X-rays reviewed
3. Tests ordered
4. Consulting physicians requested
5. Medications ordered or prescribed
6. Risks and management options
7. Reasons for all of the above



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Tips

- Notes must be complete and legible
- Signed
- Dated
- Reason for treatment must be clearly defined
- Chief complaint must be present
- When in doubt, ASK

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Laura Sullivan, MSW, CPC

Corporate Compliance Auditor/Educator

304.347.1374 work

304.532.8090 cell

304.347.1263 fax

lasullivan@hsc.wvu.edu

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