2015 New Resident Documentation

WVUPC
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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
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**
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**
History of Present Illness (HPI)

Document at least 4 of the following

- Location
- Quality
- Severity
- Duration
- Timing

- Modifying factors
- Associated signs or symptoms
- Context
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
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
Review of systems

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Integumentary
- Neurological
- Psychological
- Endocrine
- Hem/Lymph
- Allergy/Immuno

List at least 2 positives and then you can state “all other systems negative” (if they are)
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”
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

WVU Physicians of Charleston
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
• 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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