Summary Guide Documentation Elements

A presentation by: Medi-Corp, Inc.

Presentation Content

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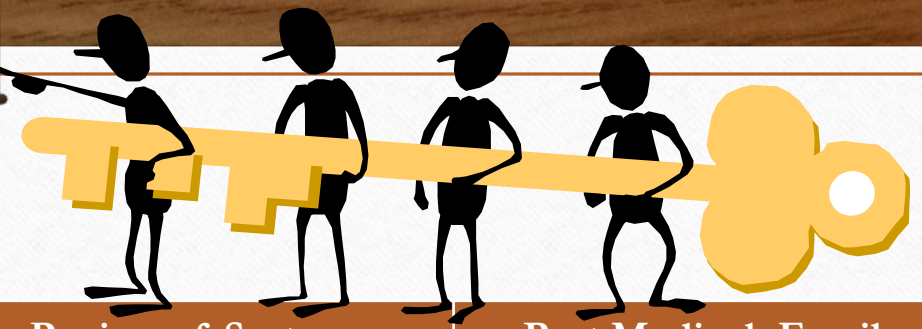
Principles of Documentation Components

Each encounter must contain the following elements:

1. Reason for the encounter, relevant history, physical examination findings, and prior test results
2. Assessment
3. Plan for Care (POC)
4. The date and legible identity of the observer (e.g. MA, NP or MD)
5. Rationale for ordering diagnostic test
6. Health Risk Factors
7. Progress, changes in treatment, and or change in diagnosis

Four Key History Elements

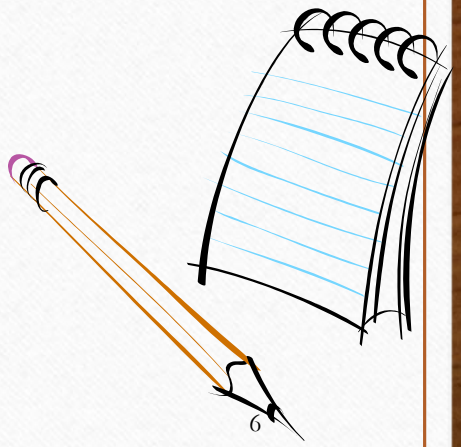


Chief Compliant	History of Present Illness	Review of System	Past Medical, Family, and/or Social History
This must be a concise statement describing: the symptom, problem, condition, diagnosis Right: Follow up visit for back pain, "complaining of back pain" Wrong: NP visit encounter , New Patient encounter	Description in chronological order, the patient's present illness; first onset of symptom to present. Note Elements: 1. Location 2. Quality 3. Severity 4. Duration 5. Timing 6. Context 7. Modifying Factors 8. Associated signs & symptoms	ROS must be relevant to the presenting illness or condition. This is an inventory of questions related to the patient's illness or condition.	1. Document the past medical has the patient's experiences with illness, injuries, treatments 2. The family history is a review of medical events in the patient's family that may place the patient at risk 3. Social history should be documented as age appropriate review of past and current activities

Recording History Elements
A Coder's Tip

Documenting History

- It is not required to re-record ROS and PFSH from a previous encounter. ***However, you must show evidence of review and update.***
- Ancillary staff may record ROS and/or PFSH. ***However, the physician must review and notate confirmation or information recorded.***
- If you are unable to obtain history from the patient, the physician must indicate the reason and all attempts made to do so.



Musculoskeletal Elements of Examination 1997 Guidelines

- Key Notes

Determine the number of body areas addressed within each examination

Inspection, percussion and/or palpation

Assessment of range of motion

Assessment of stability

Assessment of muscle strength and tone

- Examination of gait and station
- Examination of joint(s), bone(s), and muscle(s)/tendon(s) **of four of the following six areas:**

1) head and neck;

2) spine, ribs, and pelvis;

3) right upper extremity;

4) left upper extremity;

5) right lower extremity;

6) left lower extremity

Musculoskeletal Elements of Examination

The examination of a given area includes:

A. Inspection, percussion, and/or palpation, with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions

B. Assessment of range of motion with notation of any pain (e.g. straight left raising), crepitation or contracture

C. Assessment of stability with notation of any dislocation (luxation), subluxation or laxity

D. Assessment of muscle strength and tone with notation of any atrophy or abnormal movement

Key Note: For the comprehensive level of examination (4), all four elements identified by a bullet must be performed and documentation for each anatomic area. For example, assessing range of motion in two extremities constitutes two elements.

Specialty Exam: Musculoskeletal

- Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination.

Key Note: The Chest (breast); Gastrointestinal (abdomen); Genitourinary; Head/Face; Eyes; Ears, Nose, Mouth and Throat; Neck and Respiratory systems/body areas are not considered to be part of the Musculoskeletal exam.

Performed and Documented	Level of Exam
One to five bullets	Problem Focused
Six to eleven bullets	Expanded Problem Focused
Twelve to more bullets	Detailed
All bullets	Comprehensive

1995 Exam Guidelines

Performed and Documented	Level of Exam
One body area or system related to problem	PROBLEM FOCUSED EXAM
Affected body area or organ system (up to 7 systems)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of affected area(s) (up to 7 systems with more depth than above)	DETAILED EXAM
General multi-system exam or complete exam of a single organ system (8 or more system)	COMPREHENSIVE EXAM

1995 Exam Documentation
A Coder's Tip

Detailed Exam – The "Four"

4 or more items for 4 or more body areas or organ system

Constitutional	Musculoskeletal	Neurological	Psychiatric
Blood Pressure	Pain	Headaches	Depression
Weight	Stiffness (time of day, improves/worsens)	Numbness	Sleep patterns
Height	Range of motion	Weakness	Anxiety
Pulse	Joint swelling	Poor balances	Work and school performance

General Multi-System Examination
System/Body Area

Constitutional	Cardiovascular	Lymphatic	Musculoskeletal
<u>Measurements of any three of the following seven vital signs:</u> 1. Sitting or standing 2. Supine BP 3. Pulse rate and regularity 4. Respiration 5. Temperature 6. Height 7. Weight General appearance of patient (e.g. development, nutrition, body habitus, deformities, attention to grooming)	Examination of peripheral vascular system by observation (e.g. swelling varicosities) and palpation, pulses, temperature, edema, tenderness)	Palpation of lymph nodes in neck, axillae, groin, and/or other location	Examination of gait and station Examination of joint(s), bone(s), and muscle(s)/tendon(s <u>Four of the following six:</u> 1. Head and Neck 2. Spine, ribs, and pelvis 3. Right upper extremity 4. Left upper extremity 5. Right lower extremity 6. Left lower extremity

General Multi-System Examination
System/Body Area

Skin	Neurological	Psychiatry
Inspection and/or palpation of skin and subcutaneous tissue (e.g. scars, rashes, lesions, spots, ulcers) in four of the following six areas: 1) head and neck, 2) trunk, 3)) right upper extremity, 4) left upper extremity, 5) right lower extremity, and 6) left lower extremity Key Note: For the comprehensive level (4), the examination of all four anatomic areas must be performed and DOCUMENTED.	Test coordination Examination of deep tendon reflexes and/or nerve stretch test w/notation of pathological reflexes Examination of sensation	Brief assessment of mental status to include: orientation of time, place and person Mood and affect (e.g. depression anxiety, agitation)

The Value of Medical Decision Making

1. There are **three key elements** that will validate the level of Medical Decision Making.

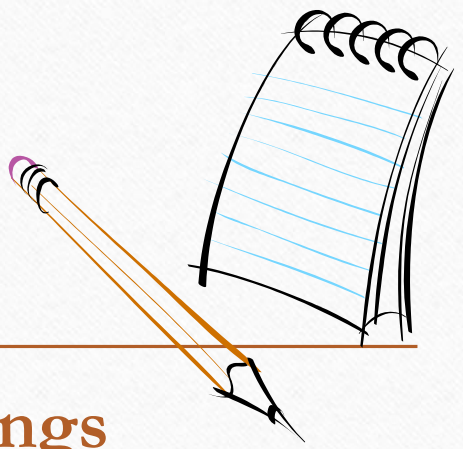
- ***The number of diagnosis and treatment options***
- ***Problems addressed during the encounter***
- ***Complexity of establishing a diagnosis***
- ***Management decisions made by the physician***

2. The amount and complexity of the data reviewed

3. The risk of complications, and/or morbidity or mortality is bases on the risk associates by:

- ***Presenting problem(s)***
- ***Diagnostic procedure(s)***
- ***Possible management options***

Medical Decision Making
A Coder's Tip



Relevant impressions

- Document all diagnoses, both tentative and confirmed, and all treatment options chosen as they related to every problem indicated within the record and found under other key components
- Summarize old records or other outside information that was utilized for the decision making

Diagnostic findings

- Remember to document clearly all diagnostic test that were ordered, reviewed, and independently visualized as part of the work of the encounter
- DO NOT bring forward studies previously reviewed on prior encounters unless medically necessary – this will not count will the coding selection

Questions?

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