INPATIENT DOCUMENTATION
Updated 7/7/2022

PURPOSE OF DOCUMENTATION
1) Supports continuity of patient care by providing an accurate picture of the visit and care provided.
2) Minimizes medicolegal risk.
3) Supports clinical revenue integrity by providing the documentation essential for optimized CPT coding, billing, and reimbursement.

CPT ELEMENTS

HISTORY OF PRESENT ILLNESS (HPI):
DOCUMENT 4+ ELEMENTS
☐ Location: Where on the patient’s body?
☐ Context: Where was patient when symptoms occurred/accident happened?
☐ Quality: What adjectives describe the signs/symptoms?
☐ Timing: When did the patient experience signs/symptoms?
☐ Duration: How long has patient had signs/symptoms?
☐ Severity: How severe are the symptoms?
☐ Modifying Factors: What has been done for symptom relief?
☐ Associated Signs/Symptoms: What else is the patient experiencing?

REVIEW OF SYSTEMS (ROS): DOCUMENT 10+ SYSTEMS
Constitution   GI   Neuro
Eyes           GU   Hem/Lymph
ENT/Mouth      Musculoskeletal Endocrine
CV             Psych Allergy/Immun.
Respiratory    Skin
☐ Document pertinent info in HPI, then: "All other systems reviewed and found to be negative."

PAST/FAMILY/SOCIAL HISTORY (PFSH):
DOCUMENT ONE ITEM IN EACH AREA
☐ Past Medical History: prior illnesses, surgeries, meds, allergies, immunizations, diet, developmental milestones, etc.
☐ Family History: family medical history, current health of relatives, causes of death, etc. or “Child was adopted, no family history available.”
☐ Social History: living arrangements, school/daycare, tobacco/alcohol/drug use, daily activities, language, social interactions, etc.

History Helpful Hints:
☐ Always use patient-specific details
☐ DO use action verbs: "I reviewed-obtained-discussed . . . “
☐ Do NOT use vague, non-specific statements: o “Other systems reviewed” (how many?) o “ROS/History negative” o “Non-contributory” or “None”
☐ Patient unable to provide a history - document WHY: “History unobtainable due patient age/family unavailable.” or “History unobtainable due to patient’s condition.”

EXAM: DOCUMENT 8+ ORGAN SYSTEMS:
Constitution   Eyes
Ears, nose, mouth & throat Cardiovascular
Respiratory    Gastrointestinal
Genitourinary  Musculoskeletal
Skin           Neurological
Psychiatric    Hematologic/Lymph/Immune

DEPARTMENT REMINDERS
☐ Verify which note type you should be using during each of your rotations (not all note types are billable on all services)
☐ Complete and forward all documentation to an attending by the end of shift.
OUTPATIENT DOCUMENTATION
Updated 7/7/2022

PURPOSE OF DOCUMENTATION
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2) Minimizes medicolegal risk.
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Number and Complexity of Problems Addressed:
Level 5: High
- 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR
- 1 acute or chronic illness or injury that poses a threat to life or bodily function

Amount and/or Complexity of Data Reviewed/Analyzed:
Level 5: Extensive (must meet the requirements of at least 2 out of the 3 categories)
Category 1: Tests, documents, or independent historian(s): Any combination of the 3 from the following:
- 1-Review of prior external note(s) from each unique source; 2-Review of the results(s) of each unique test; 3- Ordering of each unique test; 4- Assessment requiring an independent historian(s) OR

Category 2: Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); OR

Category 3: Discussion of management or test interpretation
Discussion of management or test interpretation of external physician/other qualified health care professional/appropriate source (not separately reported)

Risk of Complications, Morbidity, Mortality of Patient Mgmt:
Level 5: High Risk
- High Risk of morbidity from additional diagnostic testing or treatment
  - Examples: 1-Decision regarding hospitalization; 2- Drug therapy requiring intensive monitoring for toxicity; 3- Decision regarding emergency major surgery; 4- Decision not to resuscitate or to de-escalate care because of poor prognosis

Helpful information to include in documentation:
- Problem List
- Describe number of illnesses and their complexity: Acute? Chronic?
- Self-limited? Progression?
- Stable? Exacerbation? How Severe?
- Risk or side effects of treatment?
- Prognosis?
- Information related to the decisions, e.g. examples above
- Treatment limited by social determinants of health?
- Who did you obtain the history form? Were interpretation services required?
- Did you review medical records? (points for each unique source)
- What tests did you order? (points for each test ordered and reviewed)
- Did you personally interpret the image/specimen?
- What test results did you review? (points for each test reviewed)
- Did you discuss history, tests, or management with another provider?

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