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.

OUR CLINICAL REVENUE MISSION
1) Every patient encounter is captured in quality documentation on the correct note type and note template (check with attending or senior resident for note type and template info).
2) Documentation is forwarded to attending before leaving your shift.
3) Documentation contains CPT-defined elements needed to optimize coding for accurate capture of quantity, quality, complexity, and risk of subspecialty pediatric work – see below.
   o Note templates have built-in sections as guides, but you are ultimately responsible for thorough and quality documentation

CPT ELEMENTS

HISTORY

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 / Immunology
- 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:

- Constitutional
- Eyes
- Ears, nose, mouth & throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurological
- Psychiatric
- Hematologic / Lymph / Immune

MEDICAL DECISION MAKING

MEDICAL DECISION MAKING (MDM):
The complexity of establishing a diagnosis and/or selecting a management option

Provide comprehensive info about the patient’s clinic visit/inpatient experience, your decision-making, and thought process:

Tell the Story!

- Who did you obtain the history from? Translation services used?
- Reviewed past medical records?
- Your thought process/concerns: your “laundry list” of possibilities
- Labs / imaging / tests / procedures ordered
- Treatments ordered, drugs prescribed
- Serial exam findings
- Discussion with other providers
- Concerns for co-morbidities, chronic conditions
- Discharge info/follow-up care recommended
- List of diagnoses/symptoms (aka Problem List)