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.
   ○ 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:
  - "Other systems reviewed" (how many?)
  - "ROS/History negative"
  - "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:**

<table>
<thead>
<tr>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
</tr>
<tr>
<td>Ears, nose, mouth &amp; throat</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Genitourinary</td>
</tr>
<tr>
<td>Skin</td>
</tr>
<tr>
<td>Psychiatric</td>
</tr>
<tr>
<td>Eyes</td>
</tr>
<tr>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Neurological</td>
</tr>
<tr>
<td>Hematologic / Lymph / Immune</td>
</tr>
</tbody>
</table>

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)