

DOCUMENTATION OF MEDICAL NOTES

(Based on 1995 Guidelines)

General Principles

Medical records are legal documents.

All notes must be legible and complete. The auditor will decide if they are legible.

All services provided and reported to the insurer must relate to medical necessity and appropriateness.

The CPT and ICD-9 codes reported on an encounter form, should be supported by the documentation in the medical record.

What All Documentation Should Include

Reason for the visit.

Relevant history, physical exam findings and/or prior diagnostic test results.

Assessment, clinical impression or diagnosis.

Plan of Care.

Date.

Legible identity of provider.

The reason for ordering diagnostic and other services should be clearly stated.

Patient's progress, response to and changes/revisions in treatment/diagnosis should be documented.

Audit Triggers

Frequency of visits

A stable condition or one of fixed duration justifies more than 4 visits a year. If there are other circumstances that require a greater number of visits, these needs to be reflected on the encounter form.

Excessive Use of 1 Procedure Code

Always using 99213 or 99214 in Family Practice is a problem.

Inconsistent coding patterns among members of the same specialty/same group/same location.

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