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January 2018 **Are your charts complete?**

In documentation & coding articles, we often focus on items that would lead to downgrading of a payment; however, even worse than down-grading, is a 100% recoupment. This can occur when a chart doesn't even meet the minimum requirements of documentation. To find these requirements, I suggest starting by googling the "1997 Documentation Guidelines." This is the document that contains the basic principles of proper medical record documentation and grading. Some of you may have read it years ago, but have you glanced over it recently? I encourage you to do so.

By looking it over now and then, you will be reminded of some of the most basic elements of proper documentation. These most basic of elements is what an auditor will be looking for at a minimum. And when one or more is missing, they can very easily deem the entire record recoupable. Below is taken directly from the 1997 Documentation Guidelines.

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:

- *reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;*
- *assessment, clinical impression or diagnosis;*
- *plan for care; and*
- *date and legible identity of the observer.*

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The basic principles of this list state that records should be legible. A reason for the visit should be clearly stated followed by a RELEVANT history and physical exam. Exam findings and your impressions should be stated, along with what you are going to do about it. And there should be a signature and date. Any testing should have an order with the reason for the testing, or the reason should be easily inferred by the rest of the documentation.

Notice that number six states you should essentially explain how the patient is doing and any change to the diagnosis or treatment. This would mean that if a patient progresses from mild to moderate POAG, you should state what has caused the progression. If their IOP is now under better control, state why. These explanations add detail to the thought process. I review many charts each month and see plans of care (POC) that don't explain why a treatment plan changed. A frequent kind of POC I find is something like, "D/C latanoprost, start Lumigan." My question as a doctor is, why? Was it because the goal IOP now needs to be lower, has generic latanoprost become less effective, was there a strange insurance coverage change? The POC does not need to be a paragraph, but the "Why" needs to be there. "D/C latanoprost because of change to goal IOP to 14mmHg. Pt's RNFL shows repeatable thinning. Trial Lumigan and recheck IOP in 1 mo."

These guidelines all have the same fundamental purpose. To clearly document the care of our patients. Other providers should be able to read your charts and with little effort know why the patient came in, what was done during that visit, and what the findings were, along with what you did about the findings. All the fancy equipment in the world won't help you in an audit if the record doesn't support what you did.