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UNIT 3

Records Management

CHAPTER 7 Patients' Medical Records

OBJECTIVES

After reading this chapter and learning step-by-step procedures to gain job skills,* you should be able to:

Learning Objectives

- List reasons for maintaining medical records.
- Explain the difference between a medical record and a medical report.
- Name three basic types of medical record systems.
- State the functions of a flowchart.
- Describe the operation of an electronic medical record system.
- Name various titles the physician may have in the treatment of patients.
- List contents of a patient's medical record file.
- State the differences between a manual, an electronic, and a digital signature.
- Describe two types of documentation formats.
- Distinguish subjective from objective information.
- Define terms and common abbreviations in medical reports and chart notes.
- Name basic elements of a patient encounter included in the medical record.
- Understand the contents of a history and physical examination report.

Performance Objectives (Job Skills) in This Textbook

- Prepare and compile a medical record for a new patient.
- Correct an entry in a medical record.
- Abstract data from medical records.

**This textbook and the accompanying* Workbook *meet the educational components of the American Association of Medical Assistants Role Delineation Study of 2003 for administrative procedures and general skills.*

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Performance Objectives (Job Skills) in the *Workbook*

- Write definitions for chart note abbreviations.
- Enhance spelling skills by learning new medical words.
- Prepare a patient record from a patient information form.
- Prepare a patient record from information received in an interview.
- Decode abbreviations in medical records and know their meaning.
- Record telephone messages.
- Make proper correction entries in chart notes.
- Abstract information from a patient medical record.
- Organize the contents of a history and physical examination report.

CMA Areas of Competence

Administrative

Administrative Procedures

- Perform basic clerical functions

Clinical

Patient Care

- Obtain patient history and vital signs
- Coordinate patient care information with other health care providers

General (Transdisciplinary)

Communication Skills

- Receive, organize, prioritize, and transmit information
- Use medical terminology appropriately

Legal Concepts

- Prepare and maintain medical records
- Document accurately
- Follow federal, state, and local legal guidelines

RMA Areas of Competence

- Manage complete patient medical records system
- Arrange contents of patient charts in appropriate order and perform audits for accuracy
- Record laboratory results and patient communication in charts
- Use computer for data entry and retrieval

KEY TERMS

abstract
attending physician
audit
case history
CHEDDAR
consulting physician
diagnosis
laboratory report
medical record
medical report

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objective
ordering physician
POR
prognosis
progress report
referring physician
sign
SOAP
subjective
symptom
treating or performing physician
x-ray report

HEART OF THE HEALTH CARE PROFESSIONAL

Service

Those working with medical records serve patients by respecting their privacy and keeping personal information confidential. Consider the medical record as a diary put in your care, and have a high regard for it.

MEDICAL RECORDS

A patient's **medical record** is a handwritten or typewritten recording of information that documents facts and events during the administration of patient care. The legal task force of The American Health Information Management Association (AHIMA) defines the legal health record (LHR) as "the documentation of healthcare services provided to an individual, in any aspect of healthcare delivery by a healthcare provider organization." The principal reasons for maintaining medical records are:

1. To aid in the diagnosis and treatment of a patient
2. To provide written documentation of directed patient care
3. To verify that services were medically necessary
4. To assist in the research of disease and injuries so other patients may benefit from previous patient care
5. To substantiate procedure and diagnostic code selections for appropriate reimbursement
6. To comply with federal and state laws
7. To defend the physician in the event of a lawsuit

Patient records are also used in completing various reports required by law, such as reports on communicable diseases, child abuse, gunshot wounds, stabbings from criminal actions, diseases and illnesses of newborns and infants, and injury or illness that occurs in the workplace. In addition, they are used to assist in the preparation of insurance claims for private, federal, and state programs. A **medical report** is a permanent, legal document in either letter or report format that formally states the elements performed and the results of an examination and recommended treatment.

MEDICAL RECORD SYSTEMS

With the onset of documentation guidelines and the increase of internal and external audits, it is important that a proper medical record system be used. A good medical record system is a key to quality care. It assists with accessing patient records and protecting against liability suits. The day is fast approaching when medical record information will be available through data retrieval systems providing computer readouts so that traditional patient charts can be updated constantly.

Three basic types of record systems used by most physicians' offices are:

- Problem-oriented record
- Source-oriented record
- Integrated record

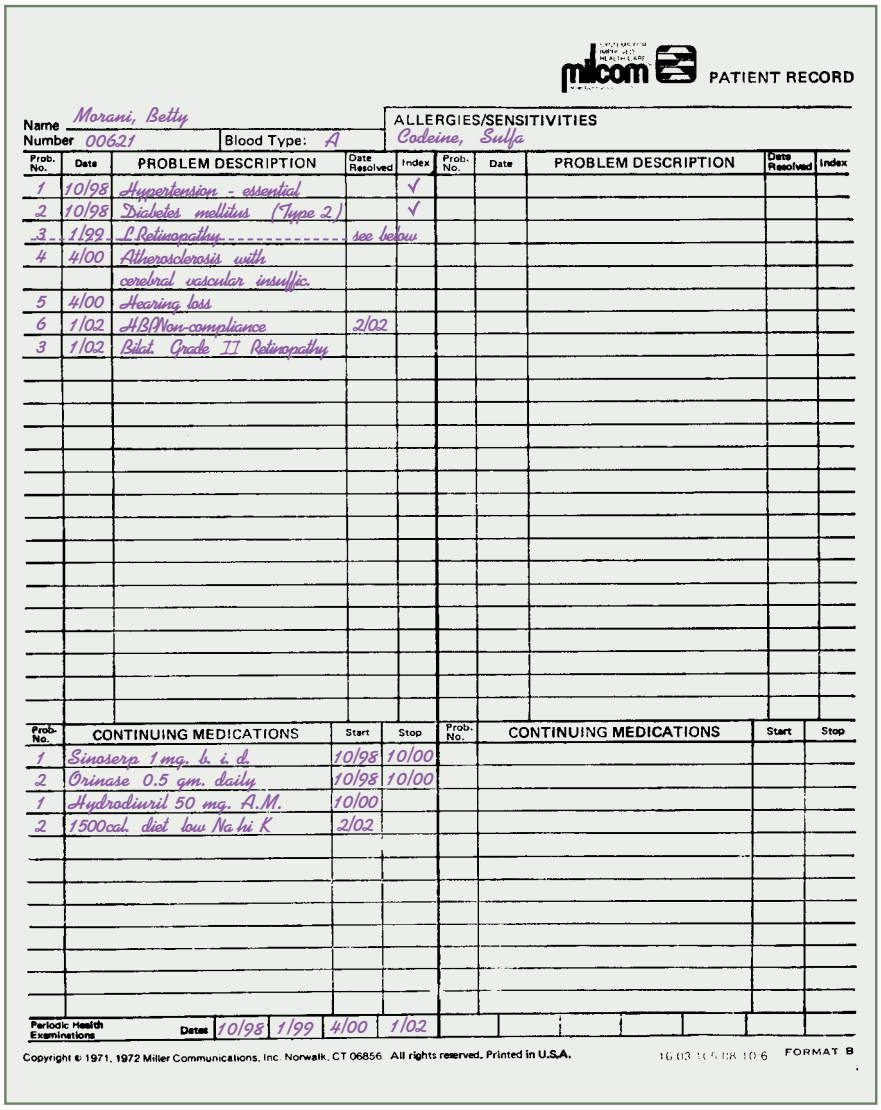
Problem-Oriented Record System

During the 1960s, Dr. Lawrence Weed developed a *problem-oriented record system* (**POR**). The system has been modified for use by individual disciplines, including the medical profession (Figure 7-1 and Figure 7-2).

The example in Figure 7-1 illustrates a flow sheet that indicates allergies, the patient's blood type, and lists in tabular form all of the patient's problems, each one numbered with the dates that they were treated and resolved. The patient's continuing medications are cross-referenced (by number) to the problem for which they were prescribed, along with dosage information and the start and stop dates of the medication.

The example in Figure 7-2 illustrates identification data with several flow sheets in the bottom portion of the form. One flow sheet lists immunizations and the dates that they were received. Another one lists consultations with the date, type, and con-

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PATIENT RECORD

Name Morani, Betty
Number 00621 Blood Type: A

ALLERGIES/SENSITIVITIES
Codeine, Sulfa

Prob. No.	Date	PROBLEM DESCRIPTION	Date Resolved	Index
1	10/98	Hypertension - essential		√
2	10/98	Diabetes mellitus (Type 2)		√
3	1/99	L Retinopathy	see below	
4	4/00	Atherosclerosis with cerebral vascular insuffic.		
5	4/00	Hearing loss		
6	1/02	HBP/Non-compliance	2/02	
3	1/02	Bilat. Grade II Retinopathy		

Prob. No.	CONTINUING MEDICATIONS	Start	Stop
1	Sinoserp 1 mg. b. i. d.	10/98	10/00
2	Orinase 0.5 gm. daily	10/98	10/00
1	Hydrodiuril 50 mg. A.M.	10/00	
2	1500cal. diet low Na hi K	2/02	

Periodic Health Examinations	Dates	10/98	1/99	4/00	1/02

Copyright © 1971, 1972 Miller Communications, Inc. Norwalk, CT 06856 All rights reserved. Printed in U.S.A. FORMAT B

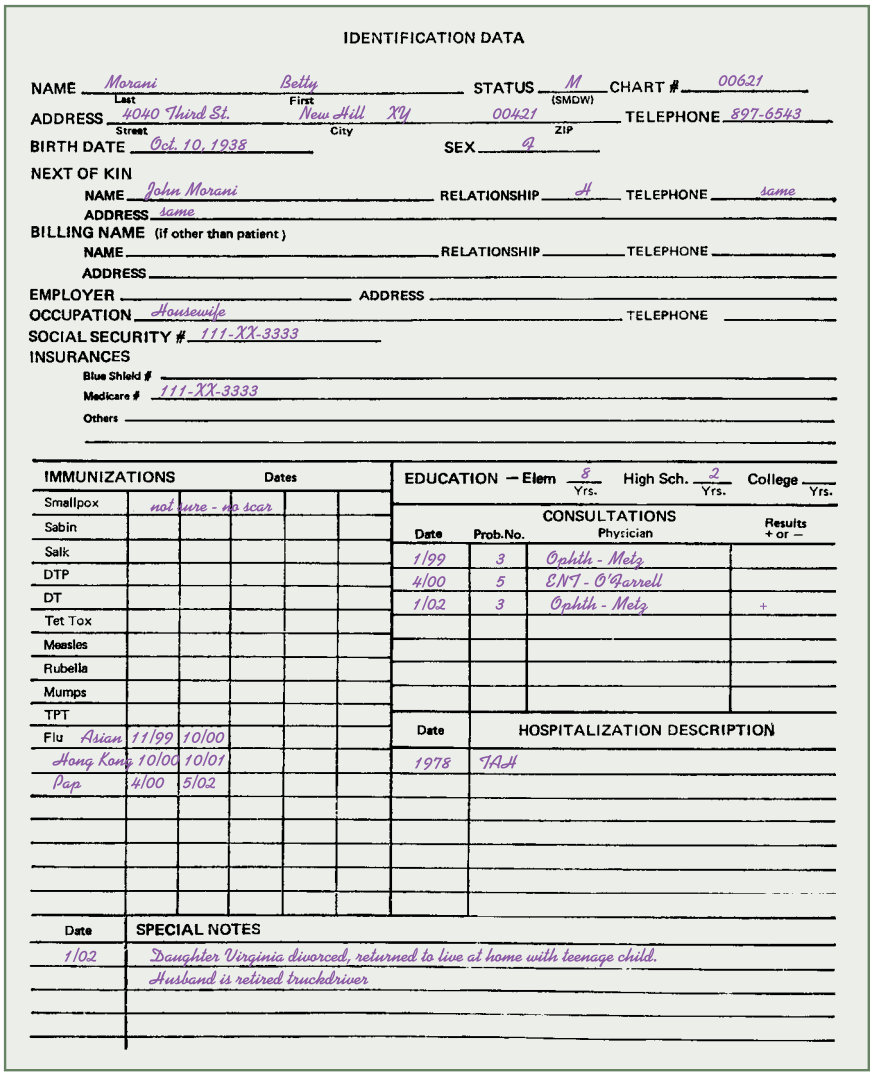
Figure 7-1. Problem-oriented medical record preprinted inside the jacket of a patient's chart. Left side with space for problem descriptions, continuing medication, and allergies and sensitivities. (Reprinted with permission of Hollister, Inc., Libertyville, IL, 1988)

sulting physician's name; the type of problem is cross-referenced by number to the problem list shown in Figure 7-2. The last flow sheet contains hospitalization dates and the reasons for admission.

Some data are hard to track in narrative progress notes; on the other hand, flow sheets, charts, or graphs allow the physician to quickly find information and perform comparative evaluations. These, however, do not replace documentation in the progress notes in the medical record. In addition to the types of flow sheets previously mentioned, they are commonly used to record blood sugar levels for diabetics, blood pressure readings for hypertensive patients, prothrombin levels for patients taking blood-thinning agents (e.g., Coumadin), weight for obese or undernourished patients, as well as medication refills. They can be developed for any type of continuous problem, for example, cardiovascular cases (see Example 7-1).

Using a medical record system helps the physician retrieve information quickly and handle large patient workloads. The POR system permits evaluation of the physician's reasoning in assessing patients' conditions.

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IDENTIFICATION DATA

NAME Morani (Last) Betty (First) STATUS M (SMDW) CHART # 00621
ADDRESS 4040 Third St. (Street) New Hill (City) KY 00421 (ZIP) TELEPHONE 897-6543
BIRTH DATE Oct. 10, 1938 SEX F
NEXT OF KIN
NAME John Morani RELATIONSHIP H TELEPHONE same
ADDRESS same
BILLING NAME (if other than patient)
NAME RELATIONSHIP TELEPHONE
ADDRESS
EMPLOYER ADDRESS
OCCUPATION Housewife TELEPHONE
SOCIAL SECURITY # 111-XX-3333
INSURANCES
Blue Shield #
Medicare # 111-XX-3333
Others

IMMUNIZATIONS	Dates				
Smallpox	not sure - no scar				
Sabin					
Salk					
DTP					
DT					
Tet Tox					
Measles					
Rubella					
Mumps					
TPT					
Flu Asian	11/99	10/00			
Hong Kong	10/00	10/01			
Pap	4/00	5/02			

EDUCATION — Elem 8 Yrs. High Sch. 2 Yrs. College ___ Yrs.

CONSULTATIONS Date	Prob.No.	Physician	Results + or −
1/99	3	Ophth - Metz	
4/00	5	ENT - O'Farrell	
1/02	3	Ophth - Metz	+

Date	HOSPITALIZATION DESCRIPTION
1978	TAH

Date	SPECIAL NOTES
1/02	Daughter Virginia divorced, returned to live at home with teenage child. Husband is retired truckdriver

Figure 7-2. Problem-oriented medical record preprinted inside the jacket of a patient's chart. Right side with space for identification data, immunizations, consultations, hospitalizations, educational status, and special notes. (Reprinted with permission of Hollister, Inc., Libertyville, IL, 1988)

There is less reliance on the physician's memory so errors are reduced, and the patient receives more efficient, continuous care. The disadvantage of this format is the time it takes to develop the problem list and to do the necessary repetitious recording.

Source-Oriented Record System

The *source-oriented record system (SOR)* is the most common paper-based management system. Documents are arranged according to sections, for example, history and physical section, progress notes, laboratory, radiology, surgical operations, and so forth. Some SOR systems use color laminated tab dividers for each section, which make locating information quick and easy. The information in each section is sequenced in chronological order, with the most recent on top. Sequencing of the sections varies from practice to practice. The disadvantage of the SOR system is the lack of an overall picture of the patient's health or problem because documentation related to these issues is filed in different sections of the record.

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EXAMPLE 7-1

Cardiovascular Flow Sheet

Patient's name: Clare McDonald				**Physician**: F. Practon, MD	
Normal Values ABC Lab	135–199	30–85	<130	L = < 3.7 M = > 3.7 H = > 4.7	35–160
Date	**Cholesterol**	**HDL**	**LDL**	**Cardiac Risk Ratio**	**Triglycerides**
1/18/1998	204	59	116	3.5	145
2/3/1999	232	61	160	3.80	57
2/17/2000	245	55	142	4.5	242
10/9/2000	256	62	178	4.1	80
2/16/2001	277	59	181	4.7	186
5/4/2002	266	50	186	5.3 Start Zocar 40 mg/d	149
9/14/2002	187	70	102	2.7	99

Integrated Record System

The *integrated record system* files all documents in chronological order without regard to their source. Trying to compare information from the same source, for example, laboratory test results, is difficult because they are scattered throughout the record. Some medical practices keep progress notes on top and other documents, such as radiology and laboratory reports, in separate sections.

Electronic Medical Record System

The use of legal, financial, clinical, and other business data has generated an ever-expanding volume of required forms, documentation, and reporting procedures. These data take more office time to document and require more storage space when a paper chart system is used.

In an electronic medical record (EMR) system, a template on the computer screen is brought up and the medical assistant enters the reason for the patient's visit (see Example 7-2). A series of questions designed to find more information about the patient's complaint are then answered.

There is one screen that may contain ongoing data about a patient, including allergies and past history of complaints. There may be a history and physical

COMPLIANCE



The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health insurance reform and administrative simplification. One of the provisions directs federal government programs to adopt national electronic standards for automated transfer of certain health care data among health care payers, plans, and providers. This eliminates nonstandard formats and encourages offices to convert to an electronic recordkeeping system.

EXAMPLE 7-2

Computer Template Questions

Chief complaint: Fever. The questions appearing in a pop-up screen might ask, "How long has the patient had a fever? What is the highest temperature reading?" "What other symptoms (chills, sweats, nausea, vomiting, rash, headache, pain) accompany the fever?"

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screen with two different templates. For example, one may be for a well-child visit and one may be for an ill-child visit. When the examination has been completed, the software program may prompt the physician through a series of templates and screens to assist in the assignment of procedural codes. When the diagnosis has been determined, a diagnostic screen appears. There are usually several diagnostic codes listed—those that were previously assigned and those relating to the current problem. The physician selects the appropriate one according to the description. With this data input, it is then possible for the system to generate either a paper claim for mailing or an electronic claim for transmission.

Electronic systems may also generate prescriptions, laboratory requisition forms, or specific written instructions for the patient to take home. There is less chance for error in reading or misinterpretation because all documents are legible.

In an electronic system, every examination room has either a computer or a physician handheld personal digital assistant (PDA). The physician can choose the typical language for normal findings already stored in the unit or mark an insertion point for edited remarks and later dictate that section of the report. There may be a workstation in the hallway or at the physician's desk to finish notes after leaving the patient. The physician can release the report to be finalized by the medical transcriptionist, who reviews and edits it for accuracy of grammar and spelling, enters any information that has been dictated, and returns the report to the physician for final review and signature. With this system, the doctor does not have to spend time redictating each component of the report for each patient.

Computers play a role in storing medical records for statistical purposes and for retrieval and review; for example, when a physician wants to evaluate data on the effectiveness of a treatment plan or follow the course of several patients who have the same diagnosis. But remember, confidentiality of the medical information must be safeguarded. Some states have laws that require human immunodeficiency virus (HIV) test results to be entered in the medical record, whereas other states do not. The inclusion of HIV test results in a medical record is not considered disclosure, and results may be disclosed to those employed in medical offices and who are involved in patient care and treatment without breaching confidentiality or the law. If a medical practice is in a state where laws require certain confidential information to be kept sealed and separate from the medical record, then a special file should be established for those cases, for example, HIV, alcohol and substance abuse, and so on. See Chapter 9 (Filing Procedures) for further discussion about this topic.



COMPLIANCE

It is imperative that an electronic medical record system provides security for both data and the system. *Data security* offers protection from improper disclosure or unauthorized or unintended alteration of information. *System security* incorporates safeguards to protect the system and its resources and data from defined threats. A protected system would include personal identification and user verification such as passwords, access codes, key cards, and biometric identification. It would also provide audit trails limiting user access and locating suspicious patterns of access. The computer architecture must be designed to prevent users from gaining access to unauthorized data and to prevent tampering. It must incorporate encryption that permits interpretation of data only with the appropriate key.

RECORDKEEPING

Recording Data

With the appearance of computers and communication equipment, there are a variety of ways to record data. Each medical practice may use one or more.

Physician enters data. Entries in the patient's record are handwritten. Physicians have been held liable in a hospital setting when medication has been given to a patient in error as a result of handwritten notes that were incorrectly read.



COMPLIANCE

Entries in the patient's record must be legible.

Physician dictates. Although some physicians prefer to handwrite, the majority dictate their notes or comments. Dictation terminals may be available at the physician's desk, in the treatment room, or at office

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workstations. Portable equipment may be used by the physician when off site. The transcriptionist listens to voice recorded data and keys the information using a typewriter, word processor, or computer. The record or report is then reviewed and signed by the physician.

Physician keys data. Data are entered via a terminal that is available in every examination room where the physician can key in information about the patient's visit. This information can be printed in the form of a progress note or medical report.

Medical assistant enters data. A checklist, form, or template is used with common problems and procedures specific to the medical practice. The assistant fills in blanks or circles an abbreviation that represents phrases or complete sentences as the physician narrates findings and recommendations. The advantage of this system is that the medical record is completed before the physician leaves the examination room. The physician can review the input before leaving the room or at a later time (Figure 7-3).

Documenters

All individuals who provide health care services may be known as *documenters* because they chronologically record facts and observations about the patient and the patient's health. There are instances when the physician's title may change, depending on the specialty and services rendered. Because this can be a confusing issue and because it is important when submitting insurance claims, clarification of these various roles is detailed here.



Figure 7-3. A medical assistant is shown checking with the physician to clarify information about a patient's condition before recording it in the medical record.

Attending physician refers to the medical staff member who is legally responsible for the care and treatment given to a patient.

Consulting physician is a provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician.

Ordering physician is the individual directing the selection, preparation, or administration of tests, medication, or treatment.

Referring physician is a provider who sends the patient for testing or treatment. It may also be the provider who transfers the management of a patient to another physician.

Treating or performing physician is the provider who renders a service to a patient.

STOP AND THINK

Attending, Consulting, Ordering, Referring, Treating, or Performing Physicians

Scenario: Kay Lenzer has been under the care of Dr. Practon for her annual physical examinations. She falls at home, suffering a compound fracture of her left tibia. Dr. Practon determines that the fracture requires treatment by a specialist and sends her to Dr. Skeleton, an orthopedic surgeon, who orders x-rays and performs surgery to stabilize the fracture. During the recovery phase, Ms. Lenzer develops a peculiar skin rash and Dr. Skeleton sends her to a dermatologist, Dr. Cutis, for an opinion about the skin ailment.

Critical Thinking: What roles do Dr. Practon, Dr. Skeleton, and Dr. Cutis play in this scenario? What titles would be given to each of these physicians?

Response/Discussion: Remember, a physician can wear more than one hat and take on more than one role. Determine your answer and justify your reasoning.

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Authentication of Documents

Manual Signatures

Typed entries made during the continuing care of the patient should be signed or initialed by the attending physician. For a chart to be admissible as evidence in court, the physician who dictated or wrote the entries must attest that the entries were true and correct at the time of writing; thus, stamped signatures are not allowed. A physician's signature or initials after the typed notes indicates this fact. If the physician is away from the office after dictating a document and the correspondence is urgent, there are two choices:

1. The assistant can sign the physician's name with his or her own initials after it.
2. A photocopy of the record (letter) may be sent, stating that the physician will sign and forward the original upon his or her return.

Electronic Signatures

In hospitals and large clinics, documents generated via computer may contain either electronic signatures or digital signatures. An *electronic signature* refers to a method of authenticating documents by the insertion of a facsimile of a person's actual handwritten signature or typed name that is affixed electronically at the end of a document. Because it can be altered, deleted, or forged by anyone with access privileges, an electronic signature creates obvious problems.

A *digital signature* is secure because it cannot be forged or altered without detection, and if the content of the signed document is altered, the signature is invalidated. To authenticate portions of the medical record, an individual has computer access and uses an identification encryption system such as a series of letters or numbers (alphanumeric computer key entries), an electronic writing, or a biometric system (voice print, hand or fingerprint transmissions, facial, iris, or retinal scans).

Documentation Format

Documentation in a patient's medical record can become voluminous. An organized system to dictate and record enables the physician and staff to locate certain sections quickly and find information. The following methods are used by physicians and have enjoyed some popularity because they were developed from acronyms that can be remembered easily.

SOAP Format

Figure 7-4 shows a progress note in a problem-oriented medical record, which is divided into four sections using the **SOAP** format. The acronym is derived from the following:

- **S**: *Subjective*—statements about how the patient feels and symptoms experienced. This would include comments by the patient about the history of present illness, responses to review of systems, and statements about the past, the family, and social history.
- **O**: *Objective*—data from laboratory reports, x-rays, other diagnostic tests, and physical findings on examination by the physician. All objective data are seen (inspection and observation), heard (auscultation), felt (palpation), or measured as in diagnostic testing.
- **A**: *Assessment*—analysis of the subjective and objective portions of the chart note.
- **P**: *Plan*—therapeutic treatment plan and instructions to the patient by the physician. This includes further testing, medications, return visit, and outlook or prognosis of the case.

CHEDDAR Format

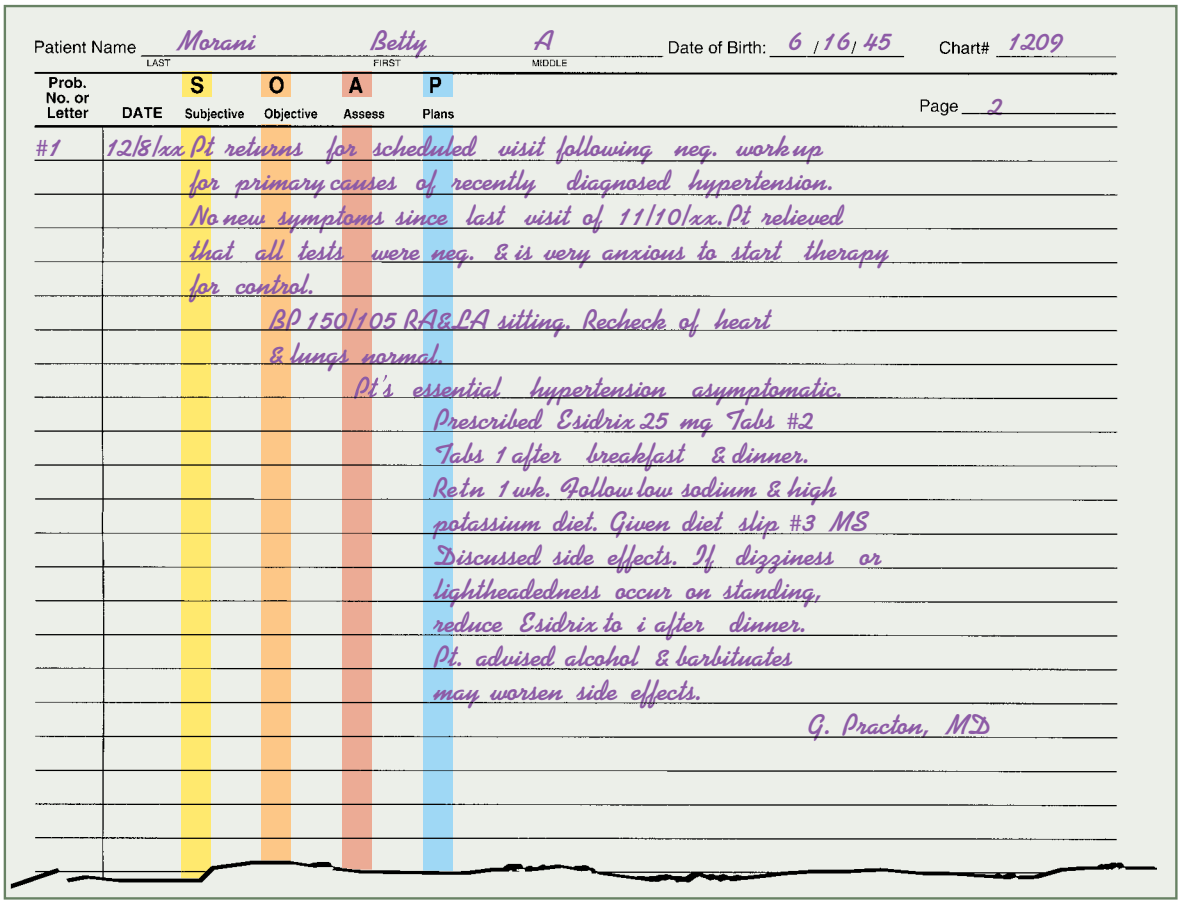
This format breaks down in further detail each element of the patient encounter. The **CHEDDAR** acronym is derived from the following:

- **C**: *Chief complaint* stated by the patient as the main reason for seeing the doctor. This is usually a subjective statement.
- **H**: *History of the present illness,* including social history and physical symptoms as well as contributing factors.
- **E**: *Examination* by the physician.
- **D**: *Details* of problems and complaints.
- **D**: *Drugs and dosages* of the current medications the patient is taking.
- **A**: *Assessment* of the diagnostic process and the impression (diagnosis) made by the physician.
- **R**: *Return visit information or referral* to a specialist for additional tests.

Documentation Guidelines

The following guidelines should be adhered to in maintaining each patient's medical record. If a med-

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Patient Name Morani (LAST) Betty (FIRST) A (MIDDLE) Date of Birth: 6/16/45 Chart# 1209

Page 2

Prob. No. or Letter	DATE	S Subjective	O Objective	A Assess	P Plans
#1	12/8/xx	Pt returns for scheduled visit following neg. workup for primary causes of recently diagnosed hypertension. No new symptoms since last visit of 11/10/xx. Pt relieved that all tests were neg. & is very anxious to start therapy for control.	BP 150/105 RA&LA sitting. Recheck of heart & lungs normal.	Pt's essential hypertension asymptomatic.	Prescribed Esidrix 25 mg Tabs #2 Tabs 1 after breakfast & dinner. Retn 1 wk. Follow low sodium & high potassium diet. Given diet slip #3 MS Discussed side effects. If dizziness or lightheadedness occur on standing, reduce Esidrix to ½ after dinner. Pt. advised alcohol & barbituates may worsen side effects. G. Practon, MD

Figure 7-4. Progress note from a problem-oriented medical record with an example of the SOAP format. (Courtesy of Bibbero Systems, Inc., Petaluma, CA. Telephone: (800) 242-2376; Fax: (800) 242-9330; Web site: http://www.bibbero.com)

ical assistant is aware of documentation deficiencies, it is his or her responsibility to bring them to the physician's attention in a tactful manner.

1. Record the patient's name and date (month, day, and year) for each entry.
2. List each patient encounter in complete form, legibly, accurately, and in chronological order.
3. Enter all documentation in a timely fashion; state information objectively and be specific, including:
   - The reason for the encounter, with relevant history, physical examination findings, and prior diagnostic test results
   - The assessment, clinical impression, or diagnosis. Avoid generalizations (e.g., patient doing well). It is considered inadequate documentation to describe test results or conditions as "normal," "abnormal," or "within normal limits."
   - The plan for care
   - The date and legible identity of the observer
4. Use standard, approved abbreviations.
5. List all allergies and history of adverse reactions.
6. Record all immunizations or injections given to the patient.
7. Prominently display the patient's problem list, and document significant illnesses and medical conditions so the list is kept current.
8. Present rationale for ordering diagnostic and other ancillary services; if not stated, documented rationale should be easily inferred.

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EXAMPLE 7-3

Elements of History of Present Illness

If a patient has chest pain, the physician may describe (1) the location of the pain (e.g., midsternal), (2) the quality of the pain (e.g., dull, sharp, stabbing), (3) the severity of the pain to further define the magnitude of the problem usually using a scale of from 1 to 10, (4) the duration of the pain (when the symptom first occurred), (5) the timing or relationship to a specific place or time of day, (6) the context or when the pain occurs, (7) all remedies and interventions that have been tried to resolve the pain (modifying factors), and (8) any associated signs and symptoms.

9. List the reasons for deviations from standard treatment.
10. Have past and present diagnoses accessible to the treating or consulting physician.
11. Identify appropriate health risk factors.
12. Include the patient's past medical history (serious illnesses, accidents, and operations).
13. Document smoking habits and/or history of alcohol or substance abuse.
14. Note the patient's medical condition on each visit, consisting of pertinent history, examination, assessment, and plan of action, including necessary follow-up by the attending physician.
15. Document all telephone conversations with or regarding the patient.
16. Document the patient's progress, response to and changes in treatment, and revision of diagnosis.
17. Support procedure and diagnostic codes reported on the health insurance claim form or billing statement with documentation in the medical record.
18. File the results of laboratory, x-ray, electrocardiogram (ECG), and other tests with the most recent report on top.
19. Read through written entries to verify that everything is legible.
20. Photocopy prescriptions written for the patient.
21. List the names of the staff members who assisted in any procedure.
22. Document any sample drugs that are given to the patient and the patient's agreement to accept the samples.
23. Indicate patient education and instructions.
24. Verify that each entry is signed or initialed by the author and include professional credentials.
25. Make all corrections using standard technique (see Figure 7-6 on page 173).

COMPLIANCE



Verify that each entry is signed or initialed by the author with his or her title or position. A signature log should be retained in the office policy handbook consisting of all staff members' names, job titles, signatures, and approved initials.

Medicare Documentation Guidelines

In November 1994, the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), developed documentation guidelines for the Medicare program. They are referred to as the 1995 guidelines. Subsequently newer guidelines were developed in 1997. These policies affect reimbursement for procedure codes used for evaluation and management services.

COMPLIANCE



Medicare has an obligation to those enrolled to ensure that services paid for have been provided and were medically necessary. Documentation must support the level of service and each procedure.

Physicians may use either the 1995 or 1997 guidelines but there is no formal requirement. However, Medicare claims processors and auditors may use them when reviewing documentation to determine that the reported services were actually rendered and that the level of service was provided.

A variety of formats of documentation (e.g., SOAP or CHEDDAR notes) are accepted by Medicare fiscal intermediaries as long as the information is discernible. Some physicians do not like to use printed forms; they prefer blank or ruled sheets for this pur-

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pose, especially if they dictate the history and physical examination findings for transcription purposes. Figures 7-5A and B show a complete, detailed medical history and physical examination.

Other physicians prefer that the medical assistant interview patients and take the medical histories. Steps should be taken so that conversations of this nature are private and not overheard by others in the reception room or throughout the office. The data may also be obtained by questionnaire or checkoff list structured with specific questions or in outline form to be completed by the patient. These forms, however, do not take the place of narrative documentation in the medical record.

If a patient is to be admitted to the hospital, a history and physical (H&P) from the office visit may be used for the hospital documentation provided it was performed one week before admission.

When significant aberrant reporting patterns are detected by Medicare fiscal intermediaries, then a review is conducted. Because these federal guidelines affect reimbursement, many medical practices have begun using these documentation policies for Medicare patients as well as those under private or managed care plans.

Documentation Terminology

Accurate words or phrases are of utmost importance when determining what charges to bill or verifying services that have been billed. Often a physician will list a normal situation or negative result by either dictating or writing "noncontributory" or "within normal limits (WNL)." Such phrases cannot be used when referring to an affected body area or to determine a diagnostic code assignment. These terms should not be used if the patient was not questioned or no examination was performed on the body part.

EXAMPLE 7-4

Documentation for Examination of Extremities

A statement such as "All extremities are within normal limits" does not indicate how many extremities or which extremities were examined. Documentation must indicate which limb was examined and what it was examined for. For example,"The left lower extremity was examined for skin rash, and no abnormalities were found."

Likewise the term *negative* as in "chest x-ray, negative" does not indicate what service the physician provided. Instead state details such as "PA and lateral chest films were reviewed and no abnormalities were seen."

When describing the status of a condition, that is, acute or chronic, the word *acute* refers to a condition with a sudden onset that runs a short but relatively severe course. The word *chronic* means a condition persisting over a long period of time. However, the word *recurrent* may be preferred for certain ailments instead of *chronic*. For example, "chronic asthma" is listed in the diagnostic code book as "recurrent asthma."

Documentation guidelines say "describe" so if the physician states "controlled hypertension" or "controlled diabetes," this is stating a fact that describes the state of the diabetes and the reason for the visit (chief complaint). However, the patient should be questioned about blood sugar level results or diet, and the physician should document the response; then a finding has been identified supporting the state of the chronic condition.

Acronyms and Abbreviations

In medical records, it is acceptable to use standard acronyms and abbreviations that are commonly understood by the general medical community. Do not invent an abbreviation. Each medical office should develop a list of standard abbreviations applicable to the specialty. To assist in this task, each local hospital has its own list of abbreviations acceptable in its facility that might be available to staff physicians on request.

Abbreviations and symbols appear in chart notes because physicians need to document quickly and eliminate long words. In many instances, it would be difficult for a layperson to interpret a chart because of the physician's shorthand. The medical assistant needs to be familiar with all the abbreviations and symbols used by the physician.

Official American Hospital Association policy is that "abbreviations should be totally eliminated from the more vital sections of the record, such as final diagnosis, operative notes, discharge summaries, and descriptions of special procedures." Many physicians are, however, unaware of this policy, and the final diagnosis may yet appear with abbreviations on the patient's record.

The current trend is to omit periods with specialized abbreviations, acronyms, and metric abbreviations as well as physicians' academic degrees (e.g.,

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HISTORY

CHIEF COMPLAINT:
Pain and restriction of motion of the right arm and a cut on the head.

PRESENT ILLNESS:
This 65-year-old Caucasian female was walking on the street when she slipped on some loose gravel and fell, landing on her right arm and striking her head against the curb. She sustained a laceration of her scalp and an injury to her right shoulder. She went home to change her clothes and started experiencing dizziness and blurred vision. She then went to the University Hospital Emergency Room by automobile where an x-ray of her right arm revealed a fracture involving the greater tuberosity of the humerus and a CAT-Scan of her head revealed a subdural hematoma.

PAST HISTORY:
The patient states that her general health has always been good except that in recent years she has suffered from spastic colitis. She had a flare-up of this condition about six months ago. Operations: T & A at age 13. A total abdominal hysterectomy in 1956. Social History: She smokes cigarettes occasionally and drinks alcohol socially only. Allergies: No known allergies.

FAMILY HISTORY:
Her father died at age 72 of a cerebrovascular accident. Her mother died at age 74 of a myocardial infarction. Three brothers, all deceased, two with cancer (age 67 and 71), and one with heart disease (age 60). Two sisters, alive and well, one has heart problems. No family history of tuberculosis or diabetes.

REVIEW OF SYSTEMS:
GENERAL: No fever, no chills, no night sweats, or weight loss.
HEENT: Blurred vision, headache, and head pain. No earaches, deafness, sore throats, hoarseness, or difficulty in swallowing.
CR: No chest pains, tachycardia, or ankle edema. No shortness of breath, chronic cough, or wheezing.
GI: Appetite good, slight nausea, no vomiting, diarrhea, constipation, or melena.
GU: No dysuria, hematuria or pyuria.
CNS: Dizziness reported. No fainting or seizures.
GYN: No spotting since her hysterectomy.

PHYSICAL EXAMINATION

GENERAL
This patient is a well-nourished, well-developed, 65-year-old Caucasian female who is awake, alert, and experiencing head pain, headache, dizziness, blurred vision, and slight nausea. She also is experiencing pain in her right shoulder when she attempts to move her right arm. Height 5'8". Weight: 155 lb. Blood pressure: 170/90. Temperature: 99°. Pulse: 100. Respirations: 20.

HEENT:
The pupils are dilated, equal, and react slowly. Extraocular movements are normal. Nasopharynx is clear. Upper and lower dentures. Ears are clear. There is a laceration measuring 2.3 cm on occipital region of scalp.

(continues)

Figure 7-5A. The first page of a medical history and results of a physical examination typed in full block report style

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NECK:
Supple with a full range of painless motion. Thyroid is not enlarged. No lymphadenopathy and no venous engorgement.

CHEST:
Symmetrical with normal expansion. Breasts: No atrophy and no masses. Lungs: Clear to auscultation. Heart: Normal sinus rhythm, no murmurs, and no enlargement.

ABDOMEN:
Soft and nontender and somewhat obese. Liver, kidneys, and spleen are not palpable.

GENITALIA:
Normal external female.

RECTAL:
Deferred.

NEUROLOGICAL:
No motor deficits. Dizziness experienced without relation to head movement. Patient is oriented to person, place, and time. Slight drowsiness occurring.

MUSCULOSKELETAL:
There is a small bruise over the anterior aspect of the left knee. The hips, knees, and ankle joints are otherwise normal. Good peripheral pulses. The right upper arm is moderately swollen and discolored. There are no other gross deformities. The patient has considerable pain with any attempt at either active or passive movement of the right shoulder.

DIAGNOSIS:
1. Laceration—occipital region of scalp measuring 2.3 cm.
2. Subdural hematoma.
3. Relatively undisplaced fracture proximal right humerus (greater tuberosity).
4. Hypertension.

TREATMENT PLAN:
Suture scalp wound. Fracture treatment (without manipulation) with right arm placed in a long arm fiberglass cast. Admit patient to hospital observation unit directly from Emergency Department. Place patient under head trauma precaution and monitor blood pressure every hour.

Gerald Practon, MD
Gerald Practon, MD
mtf
D: 2-12-XX
T: 2-13-XX

Figure 7-5B. The second page of a medical history and results of a physical examination typed in full block report style

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MD). Latin abbreviations are typed in lowercase letters with periods (e.g., b.i.d., a.m.), and many of these are pharmaceutical abbreviations (see Chapter 8). The patient care abbreviations are listed in Table 7-1. The medical assistant can use a medical dictionary to look up abbreviations not included in this table.

Illustrations

Illustrations may be used by the physician to document an area of the body where a problem occurs. They may depict a finding, symptom, or procedure and may help educate the patient or verify a completed service. Physicians may either purchase or hand draw and label their illustrations. Illustrations that are used for some aspect of a patient encounter should be kept in the chart and must be legible, dated, and signed. Include the patient's name and date of birth on the drawing.

Digital Images

Some physicians (e.g., plastic surgeons, oral surgeons) may take photographs of the patient that become part of the medical record. These may be digital images that are imported while transcribing medical reports. These images may also consist of scans of various body organs or radiographic x-rays. A graphic may help the physician determine what corrective measures to take and also makes it easier for patients to understand their condition or disease because it gives more comprehensive detailed documentation. Microsoft Word or Corel WordPerfect word processing software has a feature that allows digital images to be imported into a document. If the document is an electronic medical record, the image can be attached so other physicians can view it. If photographs are part of the medical record, be sure to label them with the patient's name, date of birth, and date taken. Remember that if a patient's digital image is requested for publication, the authorization form must contain wording that indicates the digital image is to be used in this manner.

Measurements

Measurements that pertain to lacerations, lesions, burns, nerve and skin grafts, neoplasms, tattoos, cysts, injection material, and so forth, commonly appear in patients' medical records and operative reports. Most of the time, the metric system (e.g., centimeters) is used when measuring skin lacerations and lesions. Avoid using terms such as small, medium, or large. Documentation should consist of the location and site(s), the size(s), the number(s) of lesions treated, the method of destruction, and any extenuating circumstances. Reimbursement is affected by the size or area documented and subsequently reported on insurance claims.

Burns are listed by

1. Type (e.g., chemical)
2. Depth (first, second, or third degree)
3. Site (face, arm, leg, trunk)
4. Percentage of total body surface (TBS) affected

CORRECTING A MEDICAL RECORD

To alleviate confusion and prevent medicolegal problems, it is important to know how to correct chart notes as well as other records. *Never* erase or use correction fluid on handwritten or typed entries. If corrections need to be made on a patient's medical record, draw a line neatly through the incorrect entry so it remains readable. If there is adequate room above or below the original entry, insert the correct information there. Otherwise it may be inserted in the margin or after the conclusion of the note. The person making the correction writes "Corr.," the date, and his or her initials in the margin of the page as shown in Figure 7-6. If the correction is inserted at the end of the chart note, the person making the correction enters the date, writes or types "correction to chart note of 8-10-20XX (date of note being corrected)," enters the correction, and initials or signs at the end of the notation.

It is permissible when typing a chart note or medical report to use correction fluid or tape on typographical errors at the time of typing, but one never obscures, erases, or puts self-adhesive typing strips over an original entry to correct the note later. When the physician discovers a notation, such as a progress note has been inserted into the wrong record or is missing, or needs to make a correction after an entry has been typed, it must be added as an addendum or corrected in the specified manner. For further information on making corrections, see Chapter 10.

When making a correction in a computerized document, maintain the original entry in the electronic file. Note the section in error by using highlight, underline, or score-through features found under "Tools." Enter the correct information as an addendum along with the

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Table 7-1. Patient Care Abbreviations

A	allergy; abortion
AB	antibiotic
abdom	abdomen
abt	about
Acc, acc	accommodation
AD, a.d.	right ear
adm	admit; admission; admitted
adv	advice
aet.	at the age of
$AgNO_3$	silver nitrate
AIDS	acquired immune deficiency syndrome
alb	albumin
ALL	allergy
a.m., AM	before noon
AMA	American Medical Association
ant	anterior
ante	before
A & P	auscultation and percussion
AP	anterior posterior; anteroposterior
AP & L	anteroposterior and lateral
approx	approximate
apt	apartment
ASA	acetylsalicylic acid
asap, ASAP	as soon as possible
ASCVD	arteriosclerotic cardiovascular disease
ASHD	arteriosclerotic heart disease
asst	assistant
auto	automobile
Ba	barium
BI	biopsy
BM	bowel movement
BMR	basal metabolic rate
BP, B/P	blood pressure
Brev	Brevital
BUN	blood urea nitrogen
Bx, BX	biopsy
C	cervical; centigrade; celsius
C & S	culture and sensitivity
Ca, CA	cancer, carcinoma
Cauc	Caucasian
CBC	complete blood count
cc	cubic centimeter
CC	chief complaint
CDC	calculated date of confinement
chem	chemistry
CHF	congestive heart failure
chr	chronic
CI	color index
cm	centimeter
CNS	central nervous system
CO, C/O	complains of
CO_2, CO2	carbon dioxide
comp	comprehensive
compl	complete
Con, CON, Cons	consultation
Cont.	continue
COPD	chronic obstructive pulmonary disease
CPX, CPE	complete physical examination
C section	cesarean section
CT	computerized tomography
CV	cardiovascular
CVA	costovertebral angle; cardiovascular accident; cerebrovascular accident
CXR	chest x-ray
Cysto	cystoscopy
D & C	dilatation and curettage
dc	discontinue
DC	discharge
del	delivery
Dg, Dx, dx	diagnosis
diag.	diagnosis, diagnostic
diam.	diameter
diff.	differential
dilat	dilate
disch.	discharged
DNA	does not apply
DNS	did not show
DOB	date of birth

(continues)

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Table 7-1 (continued). Patient Care Abbreviations

DPM	Doctor of Podiatric Medicine
DPT	diphtheria, pertussis, tetanus (vaccine)
Dr.	Doctor
drsg	dressing
Dx, Dg, dx	diagnosis
E	emergency
ECG	electrocardiogram; electrocardiograph
ED	emergency department
EDC	estimated date of confinement; due date for baby
EEG	electroencephalogram; electroencephalograph
EENT	eye, ear, nose, and throat
EKG	electrocardiogram; electrocardiograph
epith.	epithelial
ER	emergency room
ESR	erythrocyte sedimentation rate
est.	established; estimated
etiol.	etiology
EU	etiology unknown
Ex, exam.	examination
exc.	excision
ext	external
F	Fahrenheit; French (catheter)
FACP	Fellow, American College of Physicians
FACS	Fellow, American College of Surgeons
FH	family history
FHS	fetal heart sounds
fluor	fluoroscopy
ft	foot; feet
FU	follow-up
Fx	fracture
G	gravida (number of pregnancies)
g, gm	gram
GA	gastric analysis
GB	gallbladder
GC	gonorrhea
GGE	generalized glandular enlargement
GI	gastrointestinal
GU	genitourinary
Gyn, GYN	gynecology
H	hospital call
HA	headache
HBP	high blood pressure
HC	hospital call; hospital consultation
HCD	house call, day
HCl	hydrochloric acid
HCN	house call, night
hct	hematocrit
HCVD	hypertensive cardiovascular disease
HEENT	head, eyes, ears, nose, and throat
Hgb, Hb	hemoglobin
hist	history
H_2O, H2O	water
hosp	hospital
H & P	history and physical
HPI	history of present illness
hr, hrs	hour, hours
HS	hospital surgery
Ht, ht	height
HV	hospital visit
HX	history
HX PX	history and physical examination
I	injection
I&D	incision and drainage
IC	initial consultation
i.e.	that is
IM	intramuscular
imp., IMP	impression
inc	include
inf, INF	infected
inflam., INFL	inflammation
init	initial
inj., INJ	injection
int, INT	internal
intermed	intermediate
interpret	interpretation
IPPB	intermittent positive pressure breathing

(continues)

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Table 7-1 (continued). Patient Care Abbreviations

IQ	intelligence quotient
IV, I.V.	intravenous
IVP	intravenous pyelogram
JVD	jugulovenous distention
K35	Kollmann (dilator)
KUB	kidneys, ureters, bladder
L	left; laboratory; living children; liter
lab., LAB	laboratory
L&A, l/a	light and accommodation
L&W	living and well
lat, LAT	lateral
lbs	pounds
LLL	left lower lobe
LLQ	left lower quadrant
LMP	last menstrual period
lt., LT	left
ltd.	limited
LUQ	left upper quadrant
M	medication; married
MA	mental age
med., MED	medicine
mg	milligram(s)
MH	marital history
ml	milliliter(s)
mm	millimeter(s)
MM	mucous membrane
mo	month(s)
N	negative
NA, N/A	not applicable
NaCl	sodium chloride
NAD	no appreciable disease
neg.	negative
NP	new patient
NPN	nonprotein nitrogen
N&V	nausea and vomiting
NYD	not yet diagnosed
O_2, O2	oxygen
OB	obstetrical, obstetrics
OC	office call
occ	occasional
O.D., o.d.	right eye
ofc	office
OH	occupational history
O.L.	left eye
OP, op.	operation, operative, outpatient
OPD	outpatient department
OR	operating room
orig.	original
O.S., o.s.	office surgery; left eye
OT	occupational therapy
OTC	over the counter
OV	office visit
P	pulse; preterm parity or deliveries before term
PA	posterior anterior, posteroanterior
P&A	percussion and auscultation
PAP, Pap	Papanicolaou (test)
Para I	woman having borne one child (Para II, two children, and so on)
PBI	protein-bound iodine
PC	present complaint
PD	permanent disability
PE	physical examination
perf.	performed
PERRLA, PERLA	pupils equal, round, react to light and to accommodation
pH	hydrogen ion concentration
PH	past history
Ph ex	physical examination
phys.	physical
PI	present illness
PID	pelvic inflammatory disease
p.m., PM	after noon
PMH	past medical history
PND	postnasal drip
PO, P Op	postoperative; phone order
pos.	positive
post.	posterior

(continues)

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Table 7-1 (continued). Patient Care Abbreviations

postop	postoperative
preop	preoperative
prep	prepare, prepared
PRN, p.r.n.	as necessary
prog	prognosis
P&S	permanent and stationary
PSP	phenolsulfonphthalein
Pt, pt	patient
PT	physical therapy
PTR	patient to return
PX	physical examination
R	right; residence call; report
RBC, rbc	red blood cell
rec	recommend
re ch	recheck
re-exam, reex	reexamination
reg.	regular
ret, retn	return
rev	review
Rh-	Rhesus negative (blood)
RHD	rheumatic heart disease
RLQ	right lower quadrant
RO, R/O	rule out
ROS	review of systems
rt.	right
RT	respiratory therapy
RTC	return to clinic
RTO	return to office
RUQ	right upper quadrant
Rx, RX, ℞	prescription; any medication or treatment ordered
S	surgery
SD	state disability
SE	special examination
sed rate	sedimentation rate
Sep.	separated
SH	social history
SLR	straight leg raising
slt	slight
Smr, sm.	smear
SMWD	single, married, widowed, divorced
SOB	shortness of breath
sp gr	specific gravity
SQ	subcutaneous
SR	suture removal; sedimentation rate
STAT, stat.	immediately
STD	sexually transmitted disease
strab	strabismus
surg.	surgery
Sx.	symptoms
T	temperature; term parity or deliveries at term
T&A	tonsillectomy and adenoidectomy
Tb, tbc, TB	tuberculosis
TD	temporary disability
temp.	temperature
TIA	transient ischemic attack
TMs	tympanic membranes
TPR	temperature, pulse, respiration
Tr.	treatment
TTD	total temporary disability
TURB	transurethral resection of bladder
TURP	transurethral resection of prostate
TX, Tx	treatment
U	unit
UA, U/A	urinalysis
UCHD	usual childhood diseases
UCR	usual, customary, and reasonable
UGI	upper gastrointestinal
UPJ	ureteropelvic junction or joint
UR, ur	urine
URI	upper respiratory infection
UTI	urinary tract infection
vac	vaccine
VD	venereal disease
VDRL	Venereal Disease Research Laboratory (test for syphilis)
W	work; white

(continues)

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Table 7-1 (continued). Patient Care Abbreviations

WBC, wbc	white blood cell or count; well baby care	c̄, /c, w/	with
		p̄	after
WF	white female	s̄, /s, w/o	without
wk.	week; work	c̄c, c̄/c	with correction (eyeglasses)
wks	weeks	s̄c, s̄/c	without correction (eyeglasses)
WM, W/M	white male	+	positive
WNL	within normal limits	–, ō	negative
WR	Wassermann reaction	±	negative or positive; indefinite
Wt, wt	weight	Ⓛ	left
X	x-ray(s); multiplied by	ⓜ	murmur
XR	x-ray(s)	Ⓡ	right
yr	year	♂	male
Symbols		♀	female
*	birth	µ	micron

date, time, and your initials. Never delete or key over incorrect data in a computerized medical record file.

If the correction made to the medical record involves overpayment of an insurance claim, contact the insurance carrier, report the error, and ask for instructions regarding the overpayment. In some situations you must submit a corrected claim along with the explanation of benefits document and the corrected chart note, operative note, or other medical record document.

Michael Otani

February 22, 20xx The patient is a Japanese-American male, age 32, who came in complaining of rectal discomfort, rectal bleeding, and severe itching. PE revealed multiple soft ~~external~~ *internal* hemorrhoids.

DIAGNOSIS: Multiple internal hemorrhoids. 36 fp

TX: Rx Americaine Suppositories ~~#24~~ + a.m. & p.m. and after each bowel movement and 1 oz Americaine ointment appl. sm amt a.m. and p.m. Pt. to return in 2 weeks for a re–examination

Corr. 4/8/XX fp

Fran Practon, MD

mtf Fran Practon, MD

Figure 7-6. Typed chart note with examples of corrections made by physician Fran Practon (FP) on the day she read and signed entries

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JOB SKILL 7-1

Correct a Medical Record

Objective: To insert a correction entry in a medical chart note using standard procedures.

Equipment/Supplies: Patient's medical record, reference documents for making correction (transcribed notes, telephone notes, physician's comments, correspondence), and pen.

Directions: Follow these step-by-step procedures, which include rationales, to learn this job skill. An exercise is presented in the *Workbook* to practice this skill.

1. Draw a line neatly through the incorrect entry. It should remain readable because you do not want to suggest any altering or obliteration of a medical record.
2. Write or type the correct information either above or below the line wherever there is adequate room. If there is no space, the correction must be made on the next available section of the sheet. Refer to the date of the chart note being corrected (e.g.,"correction to chart note of 8-10-20XX"), enter the correction, and initial or sign at the end of the notation. If the correction requires an attached document, note in the record "see attached document X" and indicate where the corrected information can be found.
3. Write "Corr.," the date, and your initials in the margin of the page.

ELEMENTS OF A MEDICAL RECORD

Patient records consist of a variety of documents, such as a patient information form and a medical history questionnaire, a history and physical, progress notes, physiology reports (e.g., electrocardiography [ECG], laboratory reports, x-ray films and radiology reports), and other medical reports. If a patient has a durable power of attorney for health care or a living will and wishes to donate organs at the time of death, this information should be flagged in the patient's chart. The patient's account or ledger, which contains financial information, is also considered part of the record but is not filed with the patient record; it is maintained in a separate file. It is the medical assistant's responsibility to assist the physician in keeping the records current and accurate.

Patient Information Form

As explained in Chapter 4 and shown in Figure 4-8, the patient information form is used to obtain demographic and insurance information. It is primarily a business record but also helps acquaint the physician with a patient's personal data and becomes part of the medical record.

RECORDS AND OTHER DOCUMENTS

Laboratory Reports

Laboratory tests may be performed in the physician's office laboratory (POL) or by an outside or hospital laboratory, which sends test results to the physician's office. In the report, when normal value ranges are indicated, the medical assistant can circle, underline in red, or highlight those of the patient's values that appear higher or lower than the norms, thus calling them to the physician's immediate attention. Other laboratory reports may present abnormal values that can be easily identified (Figure 7-7). Then the **laboratory report**, along with the patient's chart, may be placed on the physician's desk. The medical assistant should never *interpret* a laboratory report to the patient in person or over the telephone. The physician must initial all laboratory reports before they are filed in patients' medical records.

Laboratory Log

When patients or their specimens are sent to an outside laboratory, it is important to be sure that the test has been done, the report has been received, the physician

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Laboratory Report

PATIENT: PETER, JAMES B.

REFERRED BY 151829 9909

AGE/SEX 78 / F
SPECIMEN NO. X1006401
PANEL

COLLECTED 01/23/98
RECEIVED 01/23/98 1:40PM
REPORTED 05/22/98 12:55PM

TEST	RESULT	HI LO	AGE/SEX SPECIFIC EXPECTED VALUES		VERY LOW	LO	RESULT DISPLAY EXPECTED	HI	VERY HI
GOLD 3									
CHEMISTRY									
GLUCOSE	318	H	85. - 125.	MG/DL					X
BUN	51	H	8. - 22.	MG/DL					X
CREATININE	6.4	H	0.7 - 1.5	MG/DL					X
BUN/CREAT	8		7.0 - 37.0				X		
URIC ACID	7.9	H	2.8 - 6.6	MG/DL				X	
CALCIUM	12.3	H	8.5 - 10.5	MG/DL					X
PHOSPHORUS	7.3	H	2.0 - 4.5	MG/DL					X
SODIUM	128	L	135. - 150.	MEQ/L		X			
POTASSIUM	6.1	H	3.5 - 5.5	MEQ/L				X	
CHLORIDE	121	H	95. - 110.	MEQ/L					X
CO2	20		20. - 34.	MEQ/L			X		
TOT PROTEIN	5.2	L	6.0 - 8.5	GM/DL		X			
ALBUMIN	3.4	L	3.6 - 5.4	GM/DL			X		
GLOBULIN	1.8		1.5 - 3.7	GM/DL			X		
A/G	1.9		1.1 - 2.3				X		
IRON	265	H	40. - 200.	MCG/DL				X	
GGTP	95	H	5. - 40.	U/L					X
SGPT(ALT)	134	H	0. - 45.	U/L					X
SGOT(AST)	178	H	0. - 41.	U/L					X
LDH	408	H	90. - 270.	U/L					X
ALK PHOS	422	H	119. - 309.	U/L				X	
TOTAL BILI	5.1	H	0.1 - 1.2	MG/DL					X
CHOLESTEROL	156		140. - 200.	MG/DL			X		
TRIGLYCERIDE	163		30. - 250.	MG/DL			X		
TOTAL LIPIDS	596		400. - 1000.	MG/DL			X		
HDL CHOLEST	55		> OR = 36	MG/DL					
CHOL/HDL	2.84		1/2 AVG. RISK	= 3.3					
			AVERAGE RISK	= 4.4					
			2X AVG. RISK	= 7.1					
			3X AVG. RISK	= 11.0					
CBC									
WBC	10.0		3.5 - 11.0	TH/CMM				X	
RBC	5.00		3.5 - 5.5	M/CMM			X		
HGB	17.0	H	11.7 - 15.7	GM/DL				X	
HCT	40.0		35. - 47.	%			X		
MCV	87		80. - 107.	MICRNS			X		
MCH	34.0		26. - 34.	PG				X	
MCHC	33.0		28. - 36.	%			X		
PLATELET CNT	375		140. - 440.	TH/CMM			X		
DIFFERENTIAL									
NEUTROPHIL	75		42.0 - 75.0	%				X	
LYMPHS	25		16.0 - 52.0	%			X		
			*** FINAL REPORT ***						

Figure 7-7. Example of a laboratory report showing the names of each test and an indication of whether the results are low, in the expected normal range, or high

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Outside Test Log

Date Ordered	Patient Name	Test Ordered	Facility Name	Date of Test	Date Report Rec'd	Test Results to Patient (Date & Initial)
1/6/XX	Kim Chang	CBC⊽ Sed Rate	ABC Lab	1/7/XX	1/9/XX	✓
1/6/XX	Bruce Johnson	UGI	College Hosp.	1/4/XX	1/17/XX	
1/7/XX	Joe Felipe	3 hr GTT	College Hosp.	1/8/XX	1/11/XX	✓
1/8/XX	Lori Carr	SerumBetaHCGQuan	ABC Lab	1/10/XX		

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Figure 7-8. Example of entries made to a test log showing when tests have been ordered and reports received

has read it, and the proper response has been made (i.e., file it or have the physician telephone the patient if there are abnormal results). Maintaining a log in a notebook, calendar book, or using a preprinted form with columns is quick and easy—more importantly, it is imperative if trying to identify which patient's laboratory results are pending (see Figures 7-8 and 7-9). Enter each report that is received and identify if a report is missing.

Radiographs (X-Ray Films)

Some physicians take x-rays in their offices and store the x-ray films in a separate file because of their size. Other physicians send their patients to a radiology group or hospital radiology department to have films taken, and these films are kept by the facility. The findings are sent to the physician in the form of an **x-ray report** to be included in the patient's medical record. If the physician takes the films and dictates the findings, the results may be included in the patient's initial history and physical examination report, progress note, or dictated in letter form.

Electrocardiograms

Some offices perform electrocardiograms (ECGs or EKGs) on patients. Special cards are available to mount the strips of paper on which ECGs are recorded. The original ECG record may be included with a patient's chart or if there is a great number, because of the bulk, a separate folder may be used. If a separate folder is used, a copy of the ECG and written interpretation is placed in the patient's record.

PATIENT MEDICAL HISTORY

The levels of evaluation and management (E/M) services are based on four types of history: problem focused (PF), expanded problem focused (EPF), detailed (D), and comprehensive (C). E/M services is a phrase used for various types of office visits when referring to procedure codes in the *Current Procedural*

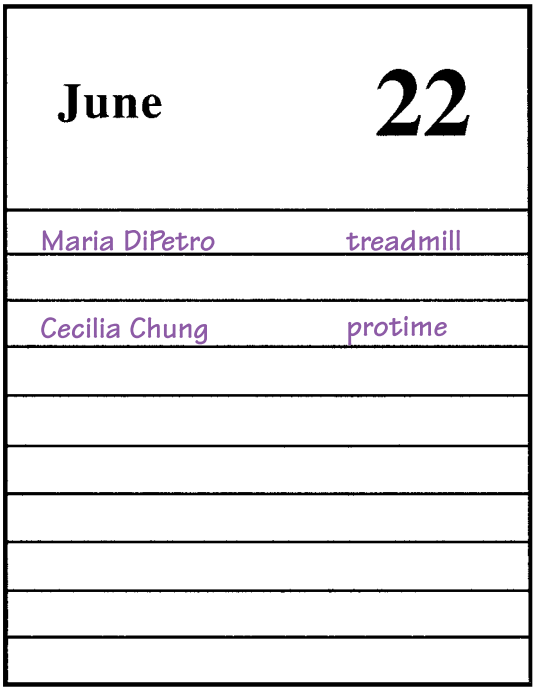


Figure 7-9. Example of entries made on the page of a flip calendar

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JOB SKILL 7-2



Prepare and Compile a Medical Record for a New Patient

Objective: To prepare and compile a medical record for a new patient.

Equipment/Supplies: File folder, patient information form, file folder label, labels for special information (current year, allergies, insurance information), typewriter or computer, forms (flow sheet, progress notes, laboratory reports, and so forth), two-hole punch, and pen.

Directions: Follow these step-by-step procedures, which include rationales, to learn this job skill. An exercise is presented in the *Workbook* to practice this skill.

1. Type or key a label for the patient's file folder with the last name followed by the first name and middle initial. Charts are filed by last name; however, if the office uses a numeric filing system, insert a number on the label.
2. Select a file folder.
3. Adhere the label to the tabbed edge of the file folder, which may be located at the right, left, or middle top portion of the folder or on the side. If a color-coded filing system is used, select the colored letters for the first two letters of the patient's last name. In larger offices additional labeling may be required. This label must be visible when the patient's record is in the filing cabinet or drawer. Colored labels aid in filing and locating lost charts because if misfiled, the color stands out from neighboring file folders.
4. Add a current year label either to the end or top tab of the file folder for a new patient. To update an established patient's record, add a year label the first time the patient comes in for an appointment for the current year. This helps when having to purge inactive files.
5. Adhere an allergy label and indicate all allergies or if there are no known allergies, write NKA. Allergy labels alert all staff members and help avoid adverse reactions.
6. Adhere an insurance label indicating the type of plan. Labels identify patients who are in specific insurance categories (e.g., HMO, PPO).
7. Insert blank forms used by the medical practice into the patient's file folder. Label each sheet with the patient's name or record number. This helps identify each page of the record.
8. Punch holes in the sheets if necessary and affix them to the folder. This will secure pages and help position information that may otherwise fall out.

Terminology code book. When a patient comes in with a complaint of symptoms describing how he or she feels, this is called **subjective** information. The history of the present illness is based on this subjective information. It is drawn from the patient's *own* words about the chief complaint (CC) and his or her response to questions asked. Depending on the specialty of the physician and the subjective symptoms, the medical history may vary. Each type of **case history** includes some or all of the following elements:

Chief Complaint

The chief complaint (CC) is a concise statement, usually in the patient's own words, describing the **symptom**, problem, condition, or other factor that is the reason for the encounter. If more than one, list them in the order of importance. *The CC is required for all levels of history*. Complaints can also be objective; if a patient complains of something that can be seen, felt, heard, or measured (e.g., a rash or a bump), it is **objective** information.

History of Present Illness

The chief complaint is followed by a detailed account of how the patient was injured or when he or she first noticed the illness, called history of chief complaint or history of present illness (HPI or PI). The HPI is a chronological description of the development of the patient's present illness from the first sign or symptom

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or from the previous encounter to the present. It includes the following elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms (see Example 7-3 on p. 164). When a symptom is demonstrable to an observer upon examination, it is an *objective symptom*, or, more generally, a **sign**.

If the patient has been treated by another physician for the same or a similar problem, this will be discussed, along with the possible diagnosis and treatment prescribed.

Past, Family, and Social History (PFSH)

The PFSH consists of a review of the following areas:

Past History (PH)

The past history is a personal history, including usual childhood diseases (UCHD), previous illnesses, physical defects, operations, accidents or injuries, treatments, medications, drug reactions, and allergies.

Medications include listing drugs the patient has taken recently or is currently taking. Allergies include any reactions the patient may have to drugs, food, or the environment. Allergies should be underlined in red in the medical record and placed on the front of the chart, boldly visible. Some medical practices list allergies at the top of each page in the patient's progress notes. Because allergies may appear as individuals age, questions should be asked each time a patient is seen for an appointment.

Family History (FH)

The family history is a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk. Notations are made regarding whether the mother and father are living and well (M & F, l & w), ages at death, cause of death, and similar information for siblings and grandparents. The place and circumstances of the patient's birth might also be noteworthy.

Social History (SH)

The social history is an age-appropriate review of past and current activities and occupational history (OH), habits, diet, alcohol, drugs, tobacco, marital history (MH), exercise, and recreational interests. Sometimes *gynecologic problems* may be a subtopic when the patient is a female. Sexual activity along with the number of pregnancies, living children, and abortions are noted. For example, gravida 3, para 2, aborta 1. The onset of menses (menarche) and the last menstrual period (LMP) are entered into the record along with any problems associated with the menstruation.

Review of Systems

A review of systems (ROS), systemic review (SR), functional inquiry, or inventory by systems is an inventory of body systems obtained through a series of oral questions seeking to identify signs or symptoms the patient might be experiencing or has experienced that may reveal information related to the present illness. The ROS should not be confused with the examination of body systems, which will follow. The ROS begins at the top of the body and continues down through each body system.

The physician may dictate ROS data with subheadings or as a single paragraph without subheadings. The medical assistant must be able to recognize the body part and divide the information as it is dictated. The following material contains descriptions of body systems and examples of words and phrases after each heading or subheading that may assist a medical assistant when keying or typing a history and physical examination report. Abbreviations that are commonly used and accepted are given where they are appropriate in the breakdown of systems and observations that follows:

Constitutional Symptoms—Physical makeup of a body and include the methods the body uses to function, actions of metabolic processes, manner and degree of reactions to stimuli, and power of resistance to disease organisms. For example, symptoms may consist of fever, weight loss or weight gain, or hot flashes.

Eyes—Assessment of the patient's perception of his or her vision functions. Symptoms and conditions concerning the eye and ocular adnexa are evaluated. These may include vision difficulties and problems such as lazy or wandering eye; glaucoma; scotoma; conjunctivitis; trachoma; pain; discharge; redness; limitation of visual fields; use of glasses, contact lenses, or intraocular lenses; blurring; double vision; seeing spots or rings around lights; watering; itching; abnormal sensitivity to light; infection of the meibomian gland on the eyelid; tear duct problems; and so on.

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Ears, Nose, Throat—Because of intercommunication between the structures of the upper respiratory tract, the ears, nose, mouth, and throat are often reviewed together.

Ears—Includes testing of the hearing and conditions such as hearing loss, discharge, dizziness, syncope, tinnitus (ringing in ears), and pain.

Nose—Includes the sense of smell and conditions such as discharges, colds, allergies, chronic sinus congestion, and epistaxis (nosebleed).

Mouth and Throat—Includes condition of teeth, dental hygiene, dentures, thyroid gland, movement of the neck, position of the trachea, and problems such as tender gums, sensitive tongue, difficulty in swallowing, hoarseness, sore throat, postnasal drip, and choking.

Cardiovascular (CV)—System that includes the heart and blood vessels. Symptoms include chest pain, angina, tachycardia, bradycardia, heart murmurs, palpitations, heart attacks, pitting or pedal edema, cool extremities, varicose veins, high blood pressure, hypotension, and so forth.

Respiratory—Exchange of oxygen is the main function of the lungs and respiratory system. Symptoms may include comments on dyspnea, orthopnea, two-pillow orthopnea, shortness of breath on exertion, wheezing, pneumonia, hemoptysis, and paroxysmal nocturnal dyspnea (PND).

Gastrointestinal (GI)—System that mechanically and chemically breaks food down to molecular size for absorption into the bloodstream to be used by the cells. The liver and gallbladder are also included in this system. Symptoms include comments on hematemesis, appetite, indigestion, melena, icterus, jaundice, anorexia, nausea, vomiting, flatus, borborygmus, flatulence, coffee-ground vomitus, stool color (black tarry or clay-colored), hematochezia, diarrhea, obstipation, dysphagia, change in weight or diet, change of bowel habits, and constipation.

Genitourinary (GU)—Review of the organs with urinary and reproductive functions. Symptoms include comments on urinary flow, incontinence, stress incontinence, burning and frequency during urination, dysuria, pyuria, nocturia, hematuria, oliguria, enuresis, sexually transmitted diseases (such as gonorrhea and syphilis), urgency or hesitancy during urination, dribbling, discharge, lumbar pain, and stones. Female: Notes on menarche (onset of menses), menstrual flow, Pap smear, obstetric history (pregnancies, deliveries, abortions), use of contraceptives. Female symptoms might include irregularity of menses, pain during intercourse, bleeding unrelated to menses, or problems associated with the onset of menopause; dysmenorrhea; menorrhagia; metrorrhagia, dyspareunia; and leucorrhea. Male symptoms might include impotence, white patches on the glans penis, and painful injury to the testes.

Musculoskeletal (MS)—System composed of the muscles, bones, and joints. Symptoms include pain, strains, sprains, stiffness, painful or swollen joints, limitation of movement, dislocations, fractures, and arthritis.

Integumentary (Skin and Breast)—System that pertains to the covering of the body (skin, hair, nails, sebaceous glands). Breasts are listed with this system because mammary glands are part of the integumentary system. Lumps found on self-examination and secretions from the nipples are symptoms of concern. Other symptoms include comments on eruptions, rashes, itches, scaling, dryness, and discolorations.

Hair—Symptoms include notes on changes in the hair texture and distribution, hair loss, and excessive hair.

Head—Symptoms include lumps, bumps, tenderness, swelling, or other abnormalities.

Neurological—Pertains to the central and peripheral nervous system. Symptoms might include loss of sensation (paresthesia) to a particular body part. Central nervous system disorders produce more severe symptoms such as headaches, vertigo, loss of consciousness, seizures, convulsions, paralysis, ataxia, or aphasia.

Psychiatric—System that deals with the interaction between the mind and body. Symptoms include comments on the emotional state of the individual (sadness, anxiety, depression, or thoughts of suicide).

Endocrine—System composed of glands and the interaction of hormones. Symptoms include over or under functioning of a gland and its hormone(s). For example, hypersecretion of thyroid hormone would produce symptoms of weakness, wasting, tremulousness, palpitations (cardiac arrhythmia), or bulging eyes.

Hematologic/Lymphatic—Blood, blood-forming structures, and the lymphatics comprise this system. Symptoms include edema, swollen or tender lymph nodes, easy bruising, frequent infections, and fatigue.

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Allergic/Immunologic—Ability to fight disease is the focus of the immune system. Symptoms include allergic reactions, frequent infections, allergic rhinorrhea (runny nose), seasonal allergies, and allergies to food or medication or drugs.

PHYSICAL EXAMINATION

General Guidelines

The physical examination (PE or PX) is objective (O) in nature; that is, it consists of findings the physician can discover by examination or through tests. The thoroughness of the examination and the determination of what body systems will be covered depend on the patient's illness or injury and on the specialty of the physician. Sometimes a checkoff list is used by the physician as each system is reviewed, and notes are made on a pad, printed form, or keyed into a personal digital assistant (PDA). Then the physician dictates the entire physical examination for the patient's medical record. Rubber stamps or stencils showing different parts of the anatomy may be used by the physician to make notes and draw arrows to various organs. These stamps can be purchased from printing firms and can be used at the time of the initial visit as well as when progress notes are made.

If the patient is going to be admitted to the hospital and has had a physical examination one week before admission, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) permits a copy of the physical examination to become part of the hospital record instead of a new history and physical (H&P) on the date of admission. If the patient has had any new development or changes between the examination date and the admission date, then these are noted in the hospital record when the patient is admitted to the hospital.

During the PE, the physician goes through four basic procedures:

1. *Inspection*, or observation, of the patient's physical characteristics and body parts.
2. *Palpation*, or touching and feeling, various parts and organs of the body.
3. *Percussion*, or striking, parts of the body with short, sharp blows, during which attention is fixed on the resistance of the tissues under the fingers and on the sound elicited to determine tissue size, density, and location.
4. *Auscultation*, or listening, to sounds of the internal parts of the body with the aid of a stethoscope.

Medicare Levels of Examination

For patients under the Medicare program, the levels of E/M services are based on four types of examination that are defined as follows:

- *Problem focused (PF)*: A limited examination of the affected body area or organ
- *Expanded problem focused (EPF)*: A limited examination of the affected body area or organ system and other symptomatic or related body areas or organ systems.
- *Detailed (D)*: An extended detailed examination of the affected body area or organ system and other symptomatic or related body areas or organ systems.
- *Comprehensive (C)*: A general multisystem examination or complete examination of a single organ system and other symptomatic or related body areas or organ systems.

The extent of the examination and what is documented depends on clinical judgment and the nature of the presenting problem or problems. They range from limited examinations of single body areas or complete single organ system examinations to general multisystem examinations.

Table 7-2 lists the body areas and organ systems that are recognized for purposes of examination.

Body Areas and Organ Systems of Physical Examination

Constitutional—Includes assessing the patient's vital signs (sitting, standing, or supine blood pressure) pulse rate and regularity, respiration, temperature, age, height, weight, race, and general appearance (development, nutritional state, body habitus, deformities, grooming, and emotional condition of the patient).

Eyes—Includes inspection of the patient's vision, ocular adnexa (area around the eye), conjunctivae, lids; examination of the pupils and irises (reaction to light and accommodation, size, and symmetry); ophthalmoscope examination of optic disks (size, C/D ratio, appearance, and posterior segments [e.g., vessel changes, exudates, hemorrhages]); extraocular movements (EOMs); and fundi (back portion of the interior of the eyeballs).

Ears, Nose, Mouth, and Throat—Includes inspection of the external auditory meatus (external ear canals);

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Table 7-2. List of Body Areas and Organ Systems for Purposes of Examination

Body Areas	Organ Systems
Head, including the face	Constitutional (vital signs, general appearance)
Neck	Eyes
Chest, including the breasts and axillae	Ears, nose, mouth, and throat
Abdomen	Respiratory
Genitalia, groin, buttocks	Cardiovascular
Back, including the spine	Gastrointestinal
Each extremity	Genitourinary
	Lymphatic
	Musculoskeletal
	Skin
	Neurologic
	Psychiatric

EXAMPLE 7-5

Constitutional Examination

In this section of the physical examination, dictation might include comments such as "appearing the stated age" or "appearing younger" or "appearing older than the stated age"; description of whether the patient is a well-developed and well-nourished male or female; body type; alertness; general state of health; whether in acute distress, in no distress, conscious, coherent, euphoric, lethargic, distracted, well oriented, or agitated.

EXAMPLE 7-6

Eye Examination

Dictation may include description of the sclerae, cornea, conjunctivae, and lids; whether pupils and irises are equal, round, react to light, and accommodation (PERRLA or PERLA); whether there are silver wire arterioles; presence of Keith-Waggoner I or II (KW I or II) changes; any retinopathy, hemorrhages, exudates, papilledema, or arteriovenous (AV) nicking; disc margins (whether flat or choked); scotoma, diplopia, arcus senilis, and aphakia.

EXAMPLE 7-7

Examination of Ears, Nose, Mouth, and Throat

Dictation about ears may indicate presence of otitis media, tinnitus, cerumen (earwax); ear discharge; and hearing. Comments on nose, mouth, and throat would include if there is a patent airway, a deviated nasal septum, whether there is rhinorrhea, or allergic rhinitis. Inspection of teeth would mention whether edentulous or presence of dentures (upper and lower plates) or carious; tongue midline and whether uncoated or coated.

tympanic membranes (TMs—eardrums); ossicles; airway, nasal septum, lips, gums, oral hygiene; tongue; oral and buccal mucosa, salivary glands; tonsils, palate, uvula, and posterior pharynx.

Neck—Includes inspection of contour; mobility (whether supple, crepitus) or any limitation of motion of the cervical spine; examination of the thyroid (size, shape, enlargement, tenderness, mass, or nuchal rigidity); position of the trachea (midline, mobile); and carotid pulses (full, equal bilaterally).

Respiratory—Includes assessment of respiratory effort (intercostal retractions, use of accessory muscles, diaphragmatic movement), auscultation of lungs (breath sounds, adventitious sounds, rubs, rhonchi, wheeze, stridor), percussion of chest (dullness,

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EXAMPLE 7-8

Neck Examination

Dictation may describe the presence of enlarged lymph nodes (whether shotty), any cervical lymphadenopathy, euthyroidism, thyromegaly, any carotid bruit, venous distention, hepatojugular reflux (jugular vein distention), and venous engorgement.

EXAMPLE 7-9

Examination of Respiratory System

Dictation would mention whether lungs are clear to inspection, palpation, percussion and auscultation (IPPA); whether rales are sibilant, musical, bubbling, or coarse; and whether at base or apex.

flatness, hyperresonant or hyporesonant), palpation of chest (tactile fremitus), lung fields, and bronchovesicular and vesicular function.

Cardiovascular—Includes palpation of the heart (location, size, thrills); auscultation of the heart with notation of abnormal sounds and murmurs; assessment of rhythm, either normal sinus rhythm (NSR) or regular sinus rhythm (RSR); borders; silhouette; heart rate; rubs, gallops, heaves, lifts; examination of carotid arteries (pulse, amplitude, bruits), abdominal aorta (size, bruits), femoral arteries (pulse amplitude, bruits), pedal pulses (pulse amplitude), and extremities for edema or varicosities.

EXAMPLE 7-10

Cardiovascular Examination

Dictation for this section may contain words and phrases, such as A2 to P2 point of maximal impulse (PMI) at the fifth intercostal space; midclavicular line (MCL); left border of cardiac dullness; systole, asystole, diastole; arrhythmia; murmurs grades II through VI (ejection, faint diastolic, harsh, soft blowing, and apical low-pitched); any physiological splitting of P2; precordium; any palpitation or opening snap.

Chest—Inspection of breasts (shape, whether symmetrical, nipple discharge); palpation of breasts and axillae (masses or lumps, tenderness), expansion (whether equal), thorax (whether bony).

Gastrointestinal (Abdomen)—Examination of abdomen; palpation of liver, spleen, and kidneys (LSK); hernia (absence or presence) symmetry, shape, and contours; scaphoid. Examination (when indicated) of anus, perineum, and rectum, including sphincter tone, presence of hemorrhoids, rectal masses. Obtain stool sample for occult blood test when indicated.

EXAMPLE 7-11

Gastrointestinal (Abdomen) Examination

Dictation may include statements about presence of masses, rebound tenderness, rigidity, guarding, any ascites; peristalsis; bowel sounds (tinkles, gurgles, rushes, borborygmus); any suprapubic tenderness, costovertebral angle (CVA) tenderness or tenderness at McBurney's point; any visceromegaly, hepatosplenomegaly, or organomegaly; any hernias (whether inguinal, reducible, femoral, ventral, incisional, umbilical); right costal margin; left costal margin; liver (two fingerwidths below the costal margin); quadrants (right upper, left upper, right lower, left lower).

Genitourinary/Male—Examination of scrotal contents, penis, digital rectal examination of prostate gland.

EXAMPLE 7-12

Genitourinary Male Examination

Dictation may include comments on whether testes is descended, penis is circumcised or uncircumcised, whether prostate is tender, boggy, firm, nodular, enlarged; whether scrotum contents show hydrocele, spermatocele, tenderness of cord, or testicular mass.

Genitourinary/Female—Pelvic examination (with or without specimen collection for smears and cultures), examination of external genitalia (general

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appearance, hair distribution, lesions), vagina (general appearance, estrogen effect, discharge, lesions, pelvic support, cytocele, rectocele), examination of urethra (masses, tenderness, scarring), examination of bladder (fullness, masses, tenderness), cervix (general appearance, lesions, discharge), uterus (size, contour, position, mobility, tenderness, consistency, descent or support), and adnexa/parametria (masses, tenderness, organomegaly, nodularity).

EXAMPLE 7-13

Genitourinary Female Examination

Dictation may include comments on external genitalia (vulva, labia, perineum); vaginal discharge; size and motion of cervix (i.e., retroflexion or anteflexion); uterine size; adnexal masses; whether parous, nulliparous, or marital introitus; results of bimanual or speculum examination; adnexal regions; uterine fundus; any cystocele or urethrocele; condition of Bartholin's duct, urethra, and Skene's duct (BUS), whether well epithelialized.

Lymphatic—Examination by palpation of two or more areas (neck, axillae, groin, other).

EXAMPLE 7-14

Lymphatic System Examination

Dictation includes comments about lymph nodes on palpation in neck (cervical), arm pit (axillary), and groin (inguinal).

Musculoskeletal—Examination of gait and station; inspection and palpation of digits and nails; examination of joints, bones, and muscles of one or more of the following six areas: (1) head and neck; (2) spine, ribs, and pelvis, (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; and (6) left lower extremity. Examination of the spine (cervical, C1 to C7; thoracic, or dorsal, T1 to T12; lumbar, L1 to L5; sacrum, S1 to S2), lumbosacral spine, sacrococcygeal spine, and coccyx.

Skin—Inspection and palpation of the skin and subcutaneous tissues.

EXAMPLE 7-15

Musculoskeletal Examination

Dictation may include comments about fingers and nails, such as clubbing, cyanosis, inflammation, petechiae, ischemia, infection, and nodes. Examination of these areas includes inspection and palpation, range of motion, dislocation or subluxation or laxity, muscle strength and tone (e.g., flaccid, cog wheel, spastic), atrophy, abnormal movements; color; temperature; any edema (whether pitting, pedal, pretibial); varicosities, clubbing, or cyanosis; pulses (pedal, peripheral, radial, femoral, popliteal, dorsalis pedis); and any intermittent claudication or stasis dermatitis. Examination of the spine would render a description of any scoliosis, lordosis, or kyphosis.

EXAMPLE 7-16

Examination of the Skin

Dictation may include description of the skin—warm, dry, moist; turgor; pallid, jaundiced, icteric, cyanotic, rashes, lesions, ulcers, induration, subcutaneous nodule, tightening. Description of the head includes shape (whether normocephalic [normal, without lumps] or exostotic [with bumps]); color and texture of the skin and hair (e.g., whether there is alopecia [balding]).

Neurologic—Test of cranial nerves with notations of any deficits for cerebral and cerebellar function; examination of deep tendon reflexes (DTR) (biceps, triceps, knee jerk, ankle jerk); examination of sensation (touch, pin, vibration, proprioception).

EXAMPLE 7-17

Neurologic Examination

Dictation may include notation of pathological reflexes (Hoffman, Babinski, Brudzinski, Gonda, Hoffmann, Kernig, Romberg, Homan, Strunsky); ankle clonus; any lingual, facial, or palatal weakness; clear sensorium; station; and gait (e.g., whether broad-based, ataxic gait).

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Psychiatric—Description of patient's judgment and insight; assessment of mental status, including orientation in all three spheres to time, place, and person, recent and remote memory, mood, and affect (depression, anxiety, agitation).

COMPLEXITY OF MEDICAL DECISION MAKING

Medical decision making is the thought process that the physician goes through. It refers to the complexity of establishing a diagnosis and selecting a management option. For Medicare patients, the levels of E/M services recognize four types of medical decision making:

- Straightforward (SF)
- Low complexity (LC)
- Moderate complexity (MC)
- High complexity (HC)

The following three elements are considered to qualify for a level of decision making:

1. *Number of Diagnoses or Management Options:* This is based on the number and types of problems addressed during the visit, the complexity of establishing a diagnosis, and the management decisions made by the doctor.
2. *Amount and Complexity of Data to Be Reviewed:* This is based on the amount and complexity of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records or to obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.
3. *Risk of Significant Complications, Morbidity, Comorbidities, or Mortality:* The level of risk is based on (1) significant complications, (2) other conditions associated with the presenting problem(s) (morbidity), (3) underlying diseases or other conditions present at the time of the visit (comorbidity), (4) the risk of death associated with the problem (mortality), (5) the diagnostic procedure(s), and (6) the possible management options (treatment rendered—surgery, therapy, drug management, procedures, and supplies).

The final section of the history and physical examination report consists of stating the diagnosis, the recommended treatment, and the prospect of recovery.

Diagnosis

The **diagnosis** is an impression, assessment, or final conclusion based on history, physical examination findings, and, sometimes, diagnostic tests such as x-rays, laboratory tests, or electrocardiogram (ECG).

Treatment

This is a recommended plan or treatment for the diagnosis. It might include admission to the hospital, physical therapy, additional tests, medication to be given with dosage, and scheduling a future appointment.

Prognosis

Prognosis is a probable outcome of the disease or injury and the prospect of recovery. It includes an estimate of partial or total disability in an accident or industrial case.

PROGRESS OR CHART NOTES

After the initial visit, the history and physical examination are recorded on the chart, and each subsequent patient visit is documented with progress notes chronologically entered in the medical record during the visit or as soon as possible after the patient leaves the office (see Figure 7-6 and Figure 7-10). For clarity and readability, it is preferred that progress notes be typed and not be handwritten. Chart notes contain information documenting each patient encounter, whether in the office, at home, in a skilled nursing facility, in the emergency room, or at the hospital. The medical assistant must check with the physician daily to find out if patients have been seen at other sites, so patient records can be pulled, entries can be made, and charges can be posted. Prescription refills need to be noted in the record, specifying frequency and dosage. If a patient is referred for a consultation, this must be stated. Telephone conversations are noted if medical advice is requested or given. Appointment cancellations or no-shows and the refusal of a patient to cooperate with instructions should also be documented on the patient's chart.

Chart notes, as part of the record, may be seen by attorneys, other physicians, and insurance companies, and may be used as evidence during litigation; therefore, they must be neat, accurate, and complete. Notes must be current, with no omissions, dated, and signed or initialed by the physician. They should be typed single-spaced or handwritten, with a line at the end of the note for the physician's signature or initials.

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Goldberg, Arlene

1-7-XX CC: Malaise, anorexia, epigastric pressure with sensation of fullness, nausea, headache, vertigo, and vomiting.
PE: Abdomen tender and rigid; esophagitis with pain and dysphagia; and severe epigastric pain.
Dx: Acute gastritis.
Rx: DC alcohol, IM inj Prochlorperazine, 10 mg.
Gave Rx for 20 Meperidine, 50 mg, q4h, orally. Retn 4 days.

Gerald Practon, MD

mtf Gerald Practon, MD

Figure 7-10. Typed chart note signed by the physician

Self-Adhesive Chart Notes

Some companies manufacture pressure-sensitive paper in single sheets or as continuous sheets that are perforated at various intervals. A series of chart notes for different patients can be typed on the paper. Take care in separating the notes for placement because brief notes can easily be placed on the wrong patient's chart. The notes are then placed on the physician's desk for initialing. Finally, each note can be carefully separated at perforations or cut apart. The backing is peeled off and each note is secured in the next available blank space of the patient's progress sheet so information previously entered is not obliterated. This eliminates the time-consuming work of obtaining each medical record and locating the proper page to type in the information.

Electronic Progress or Chart Notes

In electronic record management, chart notes may be dictated or transcribed directly into the computer system. New chart notes are printed, signed, and added to the previous notes. If passwords are used for restricted access, electronic or digital signatures may be acceptable.

ABSTRACTING FROM MEDICAL RECORDS

An **abstract** of data is required to complete reports, forms, and insurance claim forms. During this process, information is extracted from various places in the medical record and used to answer questions, fill in blanks on forms, or compose a summary. The summary should include such information as the patient's name, address, birth date, height, weight, marital history, social history, objective findings on physical examination, laboratory results, x-ray findings, diagnosis, anticipated further treatment, and prognosis.

For industrial or work-related injuries or illnesses, initial medical reports and subsequent **progress reports** are submitted until the patient has fully recovered, or until the condition is declared permanent and stationary.

AUDIT OF MEDICAL RECORDS

Internal Review

To perform an **audit** of medical records is to periodically examine or review a group of patient records. When done by the medical office staff, this process is called an *internal review*, and records may be picked at random. The purpose of the review is to verify that good recordkeeping is in place, that documentation is valid for the level of service provided and billed, and that proper medical care is being provided. There are two types of internal reviews: the *prospective review*, which is done before billing is submitted, and the *retrospective review*, which is done after billing insurance carriers. Worksheets may be used, which separate the components of the medical record to check off various items and to simplify and expedite the process.

Table 7-3 presents some of the important and most error-prone areas when reviewing documents during the process of performing an internal review.

External Audit

Government programs, managed care organizations, and private insurance carriers that have a contract

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JOB SKILL 7-3

Abstract Data from a Medical Record

Objective: To abstract data from a medical record.

Equipment/Supplies: Patient's medical record, form to insert abstracted data, and pen or pencil.

Directions: Follow these step-by-step procedures, which include rationales, to learn this job skill. An exercise is presented in the *Workbook* to practice this skill.

1. Read and review the patient's entire medical record thoroughly to become familiar with all aspects of the case.
2. Answer the following questions to see if you understand all aspects of this patient's medical record.
   a. Did this patient have surgery, and, if so, what was performed?
   b. What is the patient's diagnosis?
   c. Was any medication prescribed?
   d. Does the patient's past history show anything of consequence?
   e. Does this patient have any drug or food allergies?
   f. What is the etiology (cause) of this disease, injury, or illness?
   g. What is the prognosis for this patient's case?
   h. Was any laboratory work performed or ordered?
   i. Were any x-rays performed or ordered?
   j. Define all abbreviations listed in the patient's progress notes or history and physical examination.
   k. What documents helped you find the answers to these questions?

Table 7-3. Internal Medical Record Review

1. Confirm that the patient's name or identification number is listed on each page of documentation for the date of service reviewed.
2. Make sure dates are recorded for all entries and that the date of service matches the date on the insurance claim form.
3. Look to see if all chart entries are signed or initialed by the attending physician.
4. Check to see if allergies and adverse reactions are noted prominently so patients are not prescribed medications they will have allergic reactions to.
5. Be sure evaluation and management procedures codes conform correctly to either 1995 or 1997 documentation guidelines.
6. Check for documentation of a request from a third party when a consultation is billed.
7. Determine if handwritten progress notes are legible to an outside reviewer.
8. Check to see if there is an authorization form for release of records that was signed by the patient within the past year.
9. Verify that selected codes representing procedures and services are correct, and make sure medical necessity is documented.
10. Verify that the documented diagnosis is consistent with the diagnostic code on the insurance claim form, matches the treatment plan, and is documented for the correct date of service.

with a physician have the right to do an *external audit* of medical records. This usually occurs as the result of unusual billing patterns by a medical practice and after insurance claims have been submitted and paid. During the external audit, charts may be selected by the insurance carrier. Elements in the medical record are categorized and awarded points according to the extent of the documentation. For example, the history would be one category. Other categories might include the extent of the physical examination, complexity of medical deci-

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sion making, time, and so forth. No points are given when elements are missing. This system shows where deficiencies occur in documentation and whether billed diagnostic and procedures codes are substantiated. Investigators may question the patient, review the medical documentation and financial records, and interview the staff and all physicians who participated in the care of the patients' cases being audited. If improper coding patterns are discovered, the physician may have to refund monies or may be penalized.

WORKBOOK ASSIGNMENT



To develop competency-based job skills, refer to the *Workbook* and complete the exercises to give you practice in typing or keying patient records, making file folders, typing file cards for cross-reference, shingling laboratory reports, typing a medical history and physical examination, correcting entries on a record, abstracting information from a patient record, and learning medical terms.

COMPUTER ASSIGNMENT



To review the concepts you have learned in this chapter, insert the *Student Practice CD-ROM* into a computer and answer the multiple-choice, fill-in-the-blank, and true/false questions. Start the Medical Assisting program, then click on "To Library" in the floor plan. In the library, click on the Administrative Medical Assisting Book. Then choose Chapter 7 and start playing hangman, concentration, Tic Tac Toe, or the championship game.

RESOURCES



Magazine

ADVANCE for Health Information Professionals

Information on medical recordkeeping, medical transcription, diagnostic, and procedure coding (published biweekly—free subscription).

(800) 355-1088

Books

Dorland's Illustrated Medical Dictionary

Updated periodically—available on CD-ROM
W. B. Saunders/Elsevier Science
Philadelphia, PA
(800) 545-2522

Medical Abbreviations and Eponyms

Sheila B. Sloane
W. B. Saunders/Elsevier Science
Philadelphia, PA
(800) 545-2522

Internet

Office of the Inspector General (OIG) and Federal Bureau of Investigation

OIG national hotline: (800) HHS-TIPS
Web Site: http://www.cms.gov

American Health Information Management Association (AHIMA)

Web Site: http://www.ahima.org