# Documentation and Coding Guidelines for Athletic Trainers

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## What is documentation and why is it important?

Medical record documentation is required and needed to record pertinent facts, findings and observations about a patient. This could include past and present examinations, tests, treatments, therapies and outcomes. The medical record chronologically documents the care and treatment of patients and is an important element for quality care, for legal purposes and for billing and receiving appropriate reimbursement for services. Proper documentation also ensures the various providers of service a complete and accurate picture of the patient and their illnesses/injuries.

• Proper documentation enables the physicians and other health care providers to plan and evaluate treatments and to monitor the patient's progress, or lack of, over time.
• Documentation can facilitate communication and continuity of care between providers.
• Complete and accurate documentation can produce timely claim payment and clear audits.
• Documentation can be used for research and education, especially in the utilization and quality of care areas.

There are a number of reasons for documenting services and patient's records:

- Documentation provides the rationale for the therapy services you are providing and should show the link between services provided and desired patient outcome.
- Provide the reader of the documentation with the rationale and reasoning behind your decisions.
- Documentation will communicate to other providers medical and other information regarding the patient from your perspective as the patient's rehabilitation provider.

- The file and the documentation should create a clean chronological record of the patient and their interactions with the provider.

The AT should document all services provided within the format and method established by the practice setting, the agency, and any external accreditation agencies and/or by payers. All ATs should maintain a permanent patient record for each case. This permanent file should be kept in a professional and legal manner. It needs to be organized, clear and concise, accurate, complete and most importantly legible. Whenever you document or work with patient's files confidentiality laws and HIPAA standards must be maintained.

## Documentation

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Documentation is necessary and required for each episode of physical medicine and rehabilitative care and treatment. Documentation should be **S**ubjective, **O**bjective, include an **A**ssessment and a **P**lan.

*Subjective*-What happened to the patient, what occurred to cause this diagnosis/condition? This information is supplied by the patient
*Objective*-What is the patient's degree of motion? What is their lack or range of motion? This information is obtained from the evaluation.
*Assessment*-What have you determined to be the patient's condition, illness/injury? (i.e. diagnosis and conclusions)
*Plan*-How will you treat or correct the condition?

Additional elements to include in the documentation:

1. General health status (self reported)
2. Social habits (past and current)
3. Family illness history as well as personal illness/injury history
4. Medical/surgical history
5. Chief complaint at this time
6. Functional status-patient perceived
7. Current activity level if any and current conditions preventing desired activity level
8. Any vitamins/minerals/supplements being used, any over the counter (OTC) treatments being taken should be noted as well as prescriptive medications (include vitamins and supplements)
9. Patient's name and file number should be noted on each page of documentation.
10. Dates and type of therapy contact should be listed.
11. Using abbreviations when documenting is acceptable, as long as the abbreviations used are used consistently and their usage is commonplace.

## What Do Payers Want and Why?

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Payers may require documentation that services are consistent and in line with the benefits provided by the insurance contract. The documented medical record may serve as a legal tool to verify that care billed for was provided. Payers may

request information on the site of service, the medical necessity and appropriateness of the diagnostic or therapeutic care provided. They may also demand documentation that services provided were accurately reported and provided.

ATs must be truthful and as accurate as possible in their documentation and medical record keeping. This is especially true when it comes to billing for and receiving reimbursement from any federal or state agencies.

Proper and complete documentation will increase reimbursement and quicken the claims process.

## Guidelines For Medical Record Documentation

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Guidelines for medical record documentation are listed below; these guidelines are appropriate for most therapeutic and medical settings. The specific documentation for services may vary depending on type of service or rehabilitation performed, the site of service and the overall condition of the patient. These general guidelines may be modified depending on circumstances.

1. The medical record should be legible and complete. (Numerous third party payers report that illegible documentation is one major issue in slowing claims processing)

2. Each patient's documented record should include:
    a. The reason for this encounter and any relevant history, any physical examinations and findings, any prior test results.
    b. The diagnosis, assessment and clinical impressions
    c. The plan of care and treatment
    d. Date of service and clear identity of the provider

3. The rationale for ordering any testing or diagnostic procedures should be documented

4. Current as well as past diagnoses should be accessible to the treating or consulting provider

5. Health risk factors should be identified and noted

6. The patient's response to treatment, notes on any changes in treatment, the patient's progress or lack of and any revisions in diagnosis should also be documented

7. The CPT, ICD 9-CM and HCPCS codes listed and billed to third party payers on the claim form should be supported by the documentation contained in the medical record.

## Components Of Documentation

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The components of documentation may include *History, Examination, Medical decision making, Counseling, Coordination of care, Nature of presenting problem and Time.*

These guidelines reflect the needs for documentation for a typical adult patient. This section of documentation will be critical once ATs are allowed to work with and to bill for services provided to Medicare beneficiaries.

For certain groups of patients the information may vary slightly from what is described here. Specifically the medical records for infants, adolescents, children and pregnant women may need additional or modified information recorded in the history and examination area. Such information may include family history, details of status at birth, social history of family and family structure.

## History

Documentation of the patient's history should include:

- Chief complaint (CC)
- History of present illness or injury (HPI)
- Review of systems (ROS)
- Past, family and social history (PFSH)

The extent of the history taken and recorded is dependent on the clinical judgment and nature of presenting problem(s). The chart below shows the progression of the elements to be included for each type of history.

| HPI | ROS | PFSH | Type of History |
|---|---|---|---|
| Brief | N/A | N/A | Problem Focused |
| Brief | Problem Pertinent | N/A | Expanded Problem Focused |
| Extended | Extended | Pertinent | Details |
| Extended | Complete | Complete | Comprehensive |

The CC, ROS and PFSH may be listed as separate elements of history or may include the history and description of the present illness or injury.

## Chief Complaint (CC)

The CC is a concise statement describing the symptom(s), the problem, the condition and the diagnosis or reason for the present medical encounter or

treatment. Usually the CC is stated in the patient's own words. The medical record should clearly reflect the chief complaint.

## History Of Present Illness or Injury (HPI)

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The HPI should be a chronological description and development of the patient's present condition from the first sign and or symptom or from the previous encounter to the present. The HPI includes:

| | |
|---|---|
| *Location* | *Timing* |
| *Quality* | *Context* |
| *Severity* | *Modifying Factors* |
| *Duration* | *Associated Signs and Symptoms* |

Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical condition of the patient.
A brief HPI consists of one to three elements of the HPI. An extended HPI consists of at least four elements of the HPI.

## Review of Systems

An ROS is an inventory of body systems obtained through a series of questions designed to identify signs and symptoms the patient may be or has been experiencing.

For purposes of the ROS the following systems are recognized:

*Constitutional symptoms (e.g. fever, weight loss etc.)*
*Eyes*
*Ears, Nose, Mouth, Throat*
*Cardiovascular*
*Respiratory*
*Gastrointestinal*
*Genitourinary*
*Musculoskeletal*
*Integumentary (skin and or breast)*
*Neurological*
*Psychiatric*
*Endocrine*
*Hematologic/Lymphatic*
*Allergic/Immunologic*

The patient's positive and negative responses for the system(s) noted should be documented. A *problem pertinent* ROS inquires about the system directly related to the problem identified in the HPI. The system pertinent to the related problem. An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. Two to nine

systems.

A *complete* ROS inquires about the system(s) directly related to the problem or condition identified in the HPI plus all additional body systems. At least ten systems must be reviewed.

## Past, Family and Social History (PFSH)

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The PFSH consists of a review of three areas:

**Past history** (the patient's past experiences with illnesses, injuries, surgical procedures and treatments)
**Family history** (a review of medical events in the patient's family including diseases which may be hereditary or place the patient at risk)
**Social history** (an age appropriate review of past and current activities)

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI. At least one specific item from any of the history areas must be documented.

A *complete* PFSH is a review of two or all of the PFSH history areas. A review of all areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient.

## Documentation Of Examination

**(Physician evaluations are distinguished by the level of service provided, AT evaluation is limited to a single code 97005 and 97006 re-evaluation.)**

The level of services are based on four levels or types of exams:

*Problem focused*- A limited examination of the affected body area or organ system.

*Expanded Problem Focused*- A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).

*Detailed*- An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).

*Comprehensive*- A general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

## Coding

Documentation and the patients' file should be accurate and maintained in a timely and concise manor. The documentation and patient's file is what professional coders and billing personal will use to correctly bill for the services you've provided.
ICD-9-CM was designated in 1979 as the official system for assigning codes to diagnoses for inpatient, and outpatient care. The National Center for Health Services (NCHS) and CMS are the U.S. Department of Health and Human Services agencies that are responsible for overseeing the ICD-9-CM system. This system was adopted and is now used by private insurance carriers.

- The appropriate codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, problems, complaints or any other reason for the patient's therapy visit.
- Accurate and complete documentation is necessary for the correct ICD-9-CM code to be assigned.
- Codes 001.0 through 999.9 are used to describe reasons for the therapy visit. These codes are from the classification of injuries and diseases in the ICD-9-CM.
- Codes 780.0-799.9 describe signs and symptoms and ill-defined conditions these would be utilized when a physician has confirmed no definitive diagnosis. Though extensive they do not contain all codes for symptoms.
- V codes are used when patient encounters are for reasons other than because of an injury or illness. V01.0-V82.9
- For patients receiving rehabilitative services only, during a treatment, sequence the diagnoses listed in the medical record. First you would list the ICD-9-CM code for the primary diagnosis responsible for the outpatient services provided during that visit. Then you would list any additional diagnoses that describe co-morbidities or conditions that were treated or medically managed or that may have influenced the patient's treatment or services provided.
- E-codes describe the external causes of injury, poisoning or other adverse reactions. E-codes are descriptors and while not affecting reimbursement amounts can expedite claims processing. Using E-codes gives the claim processors a more complete picture of what happened and where the injury occurred.
- You can use more than one code when filing a claim, sometimes more is better as the claims department then understands more about the case.
- CPT codes are the procedure codes, what treatment or physical medicine activity did you perform. These are the codes used for payment; the CPT codes are the codes that third party payers reimburse by.

You should always consult your professional coder/biller for further clarification of coding and billing issues. You will also wish to consult with your compliance officer for any clarification you might need regarding documentation and record keeping.
On October 1, 2013 ICD-10 will be implemented. Anyone currently using ICD-9 should be preparing for this transition. TOP