

DOCUMENTATION OF MEDICAL NOTES

(Based on 1995 Guidelines)

General Principles

Medical records are legal documents.

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

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

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

What All Documentation Should Include

Reason for the visit.

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

Assessment, clinical impression or diagnosis.

Plan of Care.

Date.

Legible identity of provider.

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

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

Audit Triggers

Frequency of visits

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

Excessive Use of 1 Procedure Code

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

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

Documentation Of Medical Notes Based On 1995 Guidelines

VM Jensen



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Table of Contents Documentation Of Medical Notes Based On 1995 Guidelines

1. Understanding the eBook Documentation Of Medical Notes Based On 1995 Guidelines
 - The Rise of Digital Reading Documentation Of Medical Notes Based On 1995 Guidelines
 - Advantages of eBooks Over Traditional Books
2. Identifying Documentation Of Medical Notes Based On 1995 Guidelines
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Documentation Of Medical Notes Based On 1995 Guidelines
 - User-Friendly Interface
4. Exploring eBook Recommendations from Documentation Of Medical Notes Based On 1995 Guidelines
 - Personalized Recommendations
 - Documentation Of Medical Notes Based On 1995 Guidelines User Reviews and Ratings
 - Documentation Of Medical Notes Based On 1995 Guidelines and Bestseller Lists
5. Accessing Documentation Of Medical Notes Based On 1995 Guidelines Free and Paid eBooks
 - Documentation Of Medical Notes Based On 1995 Guidelines Public Domain eBooks
 - Documentation Of Medical Notes Based On 1995 Guidelines eBook Subscription Services
 - Documentation Of Medical Notes Based On 1995 Guidelines Budget-Friendly Options
6. Navigating Documentation Of Medical Notes Based On 1995 Guidelines eBook Formats
 - ePub, PDF, MOBI, and More
 - Documentation Of Medical Notes Based On 1995 Guidelines Compatibility with Devices
 - Documentation Of Medical Notes Based On 1995 Guidelines Enhanced eBook Features
7. Enhancing Your Reading Experience

- Adjustable Fonts and Text Sizes of Documentation Of Medical Notes Based On 1995 Guidelines
- Highlighting and Note-Taking Documentation Of Medical Notes Based On 1995 Guidelines
- Interactive Elements Documentation Of Medical Notes Based On 1995 Guidelines
- 8. Staying Engaged with Documentation Of Medical Notes Based On 1995 Guidelines
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Documentation Of Medical Notes Based On 1995 Guidelines
- 9. Balancing eBooks and Physical Books Documentation Of Medical Notes Based On 1995 Guidelines
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Documentation Of Medical Notes Based On 1995 Guidelines
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Documentation Of Medical Notes Based On 1995 Guidelines
 - Setting Reading Goals Documentation Of Medical Notes Based On 1995 Guidelines
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Documentation Of Medical Notes Based On 1995 Guidelines
 - Fact-Checking eBook Content of Documentation Of Medical Notes Based On 1995 Guidelines
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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