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Documentation of Patient Encounters and Procedures

The American Academy of Dermatology Association believes that documentation, charting and record-keeping are integral elements of effective and cost efficient patient care. While there is no gold standard for charting patient encounters and procedures, certain principles can guide physicians who seek to ensure the best interests of patients.

Certain elements may be **useful and relevant for patient care, and are generally included** in effective documentation of patient encounters and procedures, as described below:

1. For patient encounters that include an evaluation and management component, documentation may include a reasonably clear explanation of the patient visit, including its purpose or reason, review of systems, appropriate physical examination, other pertinent information, and a description of the assessment and plan, or actions taken.
2. For procedures and surgeries, documentation should include the indication for the procedure when such indication is not self-evident,¹ the procedure description, and, when appropriate, information pertaining to the patient disposition after the procedure.
3. When physicians perform certain practices or procedures in a manner that is consistent from patient to patient but difficult to explain, excessively space consuming, or needlessly redundant within the context of a specific medical record, they may choose to maintain a separate document listing these standard operating procedures (SOPs), and refer to these when they apply. Internal and external review of chart documentation should be viewed in conjunction with relevant local SOPs, if they exist.

Certain elements are of **lesser use and relevance for patient care, and are not included** in effective documentation of patient encounters and procedures, as described below. These lesser use elements can be distinguished from elements that are generally documented. In some cases, as specified below, abbreviations and simplifications can be used to convey chart information that is unchanged, routine, or self-evident:

1. For patient encounters that include an evaluation and management component, documentation generally is not expected to include information that is obvious or information that is not relevant to the current complaint. For both paper charts and electronic health records, patient-relevant information that has not changed but may have continuing relevance may be stored in such a way as to avoid needless duplication from note to note. However, in cases when patient-relevant information (e.g., symptoms and signs, medical history, social and family history, co-morbidities, review of systems, physical findings) that was elicited at a prior visit is actively reviewed, discussed, re-examined or reconfirmed at a current visit, and deemed appropriate to document by the physician, this may be then be incorporated in the current chart even if it is unchanged from a prior visit. When significant changes in patient-relevant information have occurred since the last visit, these are incorporated as appropriate.
2. For procedures and surgeries, commonly understood methodology can be abbreviated in a manner that is well-understood by practitioners in the field. It is not necessary to describe in detail procedures that are standard, and performed as such, without deviation from routine technique.

3. For procedures and surgeries that are performed using a consistent methodology by a particular physician, superficial variation in the wording of the documentation (e.g., rephrasing, using synonymous expressions, changing the order of phrases or sentences, or appending other patient-specific information) that provides no significant clinical benefit is not useful and may be confusing and misleading. In cases, where details of a specific procedure (e.g, anatomic location, laterality, size) may be relevant to clarify the performance of that procedure, these should be considered by the reporting physician and included in documentation as deemed appropriate. When procedures deviate from the norm for a particular physician, documentation should reflect this. When procedures do not deviate from the norm for a particular physician, it is preferable to provide consistent, uniform documentation of the parts of the procedure(s) that are done in a manner essentially identical in technique to the standard approach for that physician. In such instances the descriptive narrative of the procedure may remain identical from patient record to patient record.
4. For both evaluation and management encounters as well as procedures and surgeries, documentation should be as concise as it can be to convey the necessary information. The physician is the best judge of when additional documentation is required to convey special circumstances or to detail non-obvious procedural steps. Needless complexity and length in chart documentation can be a hindrance to timely communication of information, and can make it difficult for a caregiver to extract pertinent information.

The AADA believes that the core purpose of documentation in medical records is to optimize clinical care by providing an informative record of patient encounters and procedures. Documentation is not meant to be exhaustive, and is not the primary purpose of the patient visit. Indeed, documentation must be viewed in the context of prior and future chart notes, the physician's typical practice, and any particular guidelines that the physician maintains as standard operating procedures. Excessively long or complex documentation may be counterproductive in that it obscures relevant information, adds little to the understanding of the patient encounter, and is costly to the health care system.

The AADA strongly supports national policy designed to improve access to medical care for all Americans. As such, it is important to ensure that medical record-keeping and documentation does not consume a disproportionate amount of health care resources. Documentation should be performed to provide adequate information regarding a patient encounter and procedure.

NOTES

¹ in many circumstances, including but not limited to treatment of malignancy, phototherapy for psoriasis, or serological testing for patients on methotrexate, the indication for treatment may be self-evident.

This guidance is provided for informational and educational purposes. It is not intended to provide legal or medical advice or to establish a legal or medical standard of care. Following this guidance will not guarantee appropriate documentation in every case or assure reimbursement from third party payors. Physicians must make independent judgments about the level of documentation that is necessary in any particular case.