Notes that Pay Off

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Disclaimer

This presentation is intended for educational purposes only. It is based on guidelines established by the Centers for Medicare and Medicaid, the American Medical Association, and the American Health Information and Management Association for medical documentation of the patient record for providers, hospitals and healthcare systems.

Compliance with these guidelines is further reinforced in federal law identified in HIPAA. Failure to document the patient record accurately can result in ethical and legal inquiries, violations, fines and payment delays

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Objectives

- Identify documentation elements to correctly report Evaluation and Management Services, Labor Management, Delivery and Postpartum Care.
- Evaluation and Management Service formats utilizing Medical Decision Making and Time-Based Billing elements required to capture Antepartum and Postpartum Care.
- Accurately reporting Labor Management and Delivery Services that include necessary flow documentation as well as summary of care and transport record.
- Accurate use of EMR templates and features to ensure accuracy, privacy protection, and compliance.

The Centers for Medicare and Medicaid (CMS) Documentation Expectations 2026

CMS has announced that beginning in 2026, it has tightened its E/M documentation expectations.

This does not mean that documentation must be lengthy, but must be clearly aligned with clinical analysis, patient risk, diagnoses addressed, plan of care and these must be reflected in the code selection.

Failure to address documentation can result in payer downcoding, audits, delayed claims or reimbursement recoupments.

REMEMBER, NOT DOCUMENTED, NOT DONE!

Payers often use a "Comprehensive Error Rate Testing Program (CERT) or others that can measure errors in fee-for-service billing resulting in overpayments.

Examples of inquiries and errors identified in the documentation of Evaluation and Management (E/M) of services:

- Dates of tests ordered with results received (analysis incorrectly reported on two dates of service).
- "Incident-to-billing" – Failure to include the care plan written by the supervising physician or non-physician provider.
- Lab orders for recurring tests that meet the specific needs of an individual patient.

- Incomplete progress notes that fail to report provider documented the service according to coverage requirement.
- Medical records that fail to demonstrate authenticity or otherwise a signature requirement for payment. (no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer.
- No order or documentation of intent to order services or procedure.
- Insufficient documentation for medical services.
- Insufficient documentation to determine medical necessity
- Incorrect coding of E/M services to support medical necessity and accurate billing of those services

Focus Areas

Medical Decision Making

Clear documentation of diagnosis(es), patient risk and treatment decisions

Time Based Billing

Accurate recording of total Provider time spent on patient care on date of service

Audit Ready Notes

Consistent complete documentation that supports E/M choices

Clinical Relevance

Notes should reflect meaningful care, not copied or templated text

Telling the Patient's Story

Who

What

Where

When

Why

How

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Timeline Guidelines

- Best practices dictate completion of the charting for a patient within 24-48 hrs.
- Centers for Medicare and Medicaid Services (CMS) mandates that records be generated at the time of service or shortly thereafter, generally classifying anything beyond 48 hrs. as "unreasonable."

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Outpatient/Clinic Visits	Charting and electronic signatures 24-48 hrs.
Inpatient Visits	Daily progress and admission notes within 24 hrs.
Operative Reports	Immediately following procedure, ideally 1 hr. after procedure completion.
Labor and Delivery	Notes should be entered contemporaneously (near real time). EMR time stamps important for essential landmarks (time of birth, etc.)
Immediate Postpartum	Notes should be entered contemporaneously (near real time) due to the potential focus on blood loss and recovery of the patient.
Newborn Care	Newborn stabilization notes should be entered contemporaneously (near real time) due to the focus on recovery.
Newborn exam	Within several hours in community birth setting.

Evaluation and Management Services

Documentation Elements Relevant to Each Encounter

Chief Complaint (CC)
History of Present Illness (HPI)
Review of Systems (ROS)
Past, Family, Social History (PFSH)
Examination (E)
Assessment
Plan of Care
Medical Decision Making (MDM)

Assignment of CPT, HCPCS, ICD-10 Codes
Authentication of the Record (Signature, Date, Time, Chart Closed)

Element 1: Chief Complaint

Why: Concise statement, usually in the patient's own words that describes the primary symptom, problem, or reason for seeking medical care.

Serves as the foundation of the clinical encounter and establishes the focus for subsequent evaluation and documentation.

Clarifies to the provider why the patient is seeking care that may be not revealed to front desk or ancillary staff.

What: Patient is here in office for *"34 wk. prenatal appointment. I'm not comfortable with a back-ache. Can't sleep and I am really tired."*

A Chief Complaint is a legally required element for every Evaluation and Management Service (E/M).

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Element 2: History of Present Illness (HPI)

Why: Provides a detailed, chronological narrative of the symptoms or problem that brought a patient to a healthcare provider. It is the foundation of the medical interview and accounts for the majority of diagnoses.

What: Provider uses the patient's story and open-ended questions to identify key elements. (Acronym OLD CARTS)

Onset: When
Location: Where
Duration: How Long
Character: What
Aggravating: What Helps, What Worsens
Radiation: Where
Timing: Constant, Come and Go
Severity: Scale 1-10

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History of Present Illness (HPI) - cont.

Purpose:

- Helps the clinician build a mental list of possible conditions
- Builds trust and ensures the patient's experience is heard
- Documentation – Identifies key elements of the chief complaint and elements relevant to focusing encounter.

Only explore components relative to the patient's needs identified in this encounter.

Element 3: Review of Systems (ROS)

Choose those relevant to purpose of visit

Why: Separate from the "HPI", which describes the "Chief Complaint"

The Review of Systems is a broader view of body systems gathered from the patient encounter.

Serves to uncover subjective symptoms the patient may be experiencing or recently experienced, helping clinicians identify hidden issues, validate diagnoses and ensure comprehensive care.

What:

Constitution	fevers, weight loss, chills, fatigue
Eyes	vision changes, pain discharge
HEENT	congestion, sore throat, hearing loss
Cardiovascular	chest pain, palpitations, edema
Respiratory	cough, shortness of breath, wheezing
Gastrointestinal	nausea, vomiting, diarrhea, abdominal pain
Musculoskeletal	joint pain, swelling, back pain

Review of Systems (ROS) - cont.

What:

Integumentary	skin rashes, lesions, mole changes
Genitourinary	odor, itching, dysuria, frequency, blood in urine
Neurological	headaches, dizziness, numbness, weakness
Psychiatric	anxiety, depression
Endocrine	heat/cold tolerance, excessive thirst
Hematologic/Lymph	easy bruising or bleeding
Allergic/Immunologic	food or seasonal allergies

Review of systems should be problem-focused unless done for a wellness exam or initial history to establish care.

Only relevant systems related to the patient-identified issues should be previewed.

May be queried by ancillary staff with patient, but provider must review and explore relevant issues identified.

Review of systems assists the provider in focusing the physical exam.

Do not give a blanket statement "All are negative." Only explore those relevant to encounter.

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Element 4: Past, Family, Social History (PFSH)

Why: Core component of the patient's medical record

Identifies inherited risks relevant to care, environmental exposures, lifestyle factors

Providers review and update data to personalize screenings, formulate diagnoses and plan treatments.

What: Past medical history (PMH). Documents patient experiences with illnesses, hospitalizations, injuries, allergies, medications.

Family history (FH). Details 1st and 2nd degree relative for relevant medical events, chronic diseases, causes of death within bio family.

Social history (SH). Age-appropriate review of patient's lifestyle, environment and personal life.

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Past, Family, Social History (PFSH) cont.

What (cont.) Health habits, alcohol and drug use, living arrangements, educational level, occupation challenges, financial obstacles, housing, life stressors impacting health. Microaggressions.

Necessary component for meeting higher complexity levels of care.

Purpose: Establish a comprehensive history relevant to the visit. A thorough PFSH is important for initial history to establish care or annual exam.

Relevant information may be elevated to a primary focus in some areas if the provider determines necessity. Items may be added to the problem list or added as "history of" status.

Element 5: Physician Exam (PE)

Why: Structured under a head-to-toe or body exam **relevant to the type of encounter.**

What:

- Vital signs
- General appearance
- HEENT
- Neck
- Respiratory
- Cardiovascular
- Abdomen
- Musculoskeletal
- Neurological
- Psychiatric
- Skin

Element 6: Summary, Plan of Care, Medical Decision Making

Why: The summary of care represents the story of the encounter-the what, when, where, why, how of the encounter in a concise manner.

What: Chief Complaint

Pertinent review of systems

Objective findings including relative physical exam elements, clear identification of any severity of the patient's condition.

Education Anticipatory guidance outlined with any shared decision-making elements, consents, waivers, documentation of patient understanding

Best practice is to upload all educational materials into the EMR with an outline as to weeks covered and then reference in the documented encounter.

Counseling Document topics of counseling, degree of stress, referrals, plan of care

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Notes or Free Text

S	**Subjective**	What does the patient say? Chief Complaint, HPI, ROS, Family/Social Hx, Medications, Allergies
O	**Objective**	Vital Signs, Physical Exam Findings, Lab and/or Imaging Results, Other diagnostic data, Review of Records
A	**Assessment**	Medical Decision Making, Diagnosis(es)
P	**Plan**	Plan of Care, Patient Discussion, Shared Decision Making, Provider Orders, Education, Follow up

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Documentation Best Practices

Document all required components concisely, with attention to specificity.

Before signing the document, reread with attention to how it flows from a third-party point of view.

Does it answer all relevant questions of “Who, What, Where, When, Why, How?”

Each encounter note must stand on its own with complete documentation of all relevant to this encounter. Do not reference another provider’s note, or state, “See above note.”

Prior to every encounter, read the record and document that the patient’s record was reviewed, including labs, images, and any consults.

Do not state “follow-up-appointment.” Instead document the course from previous appointment, address relevant information for current appointment and plan for care.

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Education and Counseling

Time spent in education and counseling is billable and does increase the value of the patient encounter.

Special documentation must be included to validate the medical necessity that justifies additional time spent.

Education

Devise a teaching sheet and use that to check off what was covered at each encounter.

Include descriptions of each topic covered in your practice protocols, including any handouts.

Reference the sheet in your documentation. Document the time spent.

Counseling

Document counseling component using SOAP format separately in the text of the note.

Document discussion including medical necessity of the counsel.

Include patient responses as to understanding. Document the time spent.

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CMS Formats

Code Selection Determination

Medical Decision Making (MDM)

Best for complex clinical cases where face-to-face time is short but cognitive load is high

Time-Based Billing (TBB)

Best for counseling heavy visits, prolonged coordination, extensive chart review

Medical Decision Making (MDM)

Complexity Components

Straightforward | **Low** | **Moderate** | **High**

Each E/M Code reported must based on the complexity of the services provided

- Problem(s) Addressed - Pregnancy as a condition reported here
- Amount and/or Complexity of the Data Reviewed and Analyzed
- Risk of complications and/or morbidity or mortality of patient

Each of these criteria contains definitions as to what constitutes each level

Requires 2 out of 3 components for choice of Medical Decision Making Complexity.

Problem Addressed Component Medical Decision Making

ACOG Statement: “For the purpose of E/M coding ONLY, “pregnancy should be considered as one or more chronic illnesses with exacerbation, progression or side effects of treatment due to the inherent complexity of treating the pregnant person and fetus simultaneously.”

This aligns with a statement made by the AMA in 2023 prior to the development of the new codes

* Problems Addressed Component for Pregnancy: **MODERATE**

Complexity - Straightforward

Straightforward

Problems	
#s and Complexity	Self-limited or minor problem
Data	
Amt and Complexity	Minimal or no data reviewed or analyzed
Risk	
Management Treatment	Minimal risk of morbidity from treatment

Complexity - Low

Low

Problems

#s and Complexity	2+ minor problems or 1 stable illness or 1 acute uncomplicated illness or injury

Data

Amt and Complexity	CAT 1 Tests or Documents 2 of tests, documents, discussions or independent interpretation. Ordering and/or reviewing Pap Smear and pelvic ultrasound or review note from outside provider. Discussion with outside provider, discussion of management or interpretation with outside provider.

Risk

Management Treatment	Low Risk Treatment OTC drugs, hospitalization (observation or admission).

Must meet 2 out of 3 components.

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Complexity - Moderate

Moderate

Problems

#s and Complexity	Pregnancy should be considered as one or more chronic illnesses with exacerbation, progression or side effects of treatment due to the inherent complexity of treating the pregnant person and fetus simultaneously. ACOG/AMA 2023.

Data

Amt and Complexity	CAT 2 Tests, documents, independent interpretation Must meet 3 unique elements (reviewing external notes, ordering, reviewing unique tests, using independent historian independent interpretation or discussion w/ external provider)

Risk

Management Treatment	Rx drug management, decision-making for surgery, management impacted by social determinants of health

Must meet 2 out of 3 components.

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Complexity - High

High

Problems

#s and Complexity	1+ chronic illnesses w/severe exacerbation OR 1 acute or chronic illness /injury that threatens life or bodily function

Data

Amt and Complexity	CAT 3 Must meet 3 categories. Review of external notes from 3 unique sources. Review of results of unique tests, ordering unique tests, independent interpretation of a test performed by another provider. Discussion with external physician or source.

Risk

Management Treatment	Drug therapy monitoring for toxicity, immunosuppressants, elective major surgery w/ risks, emergency surgery, hospitalization for complexity

Must meet 2 out of 3 components.

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Time-Based Billing

Documentation Criteria

Providers can elect to report based on time that captures the total day workload based on both face-to-face time and non-face-to-face time spent.

Document total time spent providing services to the patient over the course of the date of service.

> This includes: Face-to-face, non-face-to face time history, assessments, orders, coordination of services, education, counseling, discussion with family. Services provider must meet medical necessity criteria, along with shared decision making, consents, waivers. Documentation must be specific.
>
> An accurate record of time spent must be documented.

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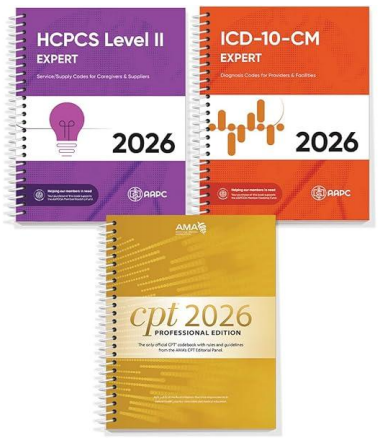
Categories of Medical Codes

CPT Codes
ICD-10 Codes
HCPCS Codes



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CPT Codes - Current Procedural Terminology

Answers the Question "WHAT"

- Update January 1 of every year
- Separated into Category Sections
- Specific Guidelines Precede Each Section

CPT Category 1 Codes

Evaluation & Management	**99202-99499**
Anesthesia	**00100-01999**
Surgery (broken into smaller groups by body area and systems)	**10021-69990**
Radiology	**70010-79999**
Pathology and Laboratory	**80047-89398**
Medicine Services and Procedures	**90281-99607**

***Labor Management and Delivery Codes are Included in the Surgery Section**

Who Can Bill E/M Visits

Physicians MD, DO
Non-Physician Providers
- Advanced Practice RNs
  - Nurse Midwives
  - Nurse Practitioners
  - Clinical Nurse Specialists
- Physician Assistants
- Licensed or Certified Professional Midwives (scope approved by jurisdiction)

Other Specialists
- Licensed Clinical Social Workers
- Licensed Clinical Psychologists
- Therapists who bill specific psychiatric/therapy-based E/M codes
- IBCLCs/Lactation Consultants (dependent on jurisdiction and payer rules)
- Doulas (dependent on judrisdiction and payer rules)

***Clinical Staff may never bill these codes independently.**

New vs. Established Patient

New patient is one who has not received any services, Evaluation & Management (E/M) or other face-to-face service (e.g., surgical procedure) from the same provider or provider group practice (same provider specialty) within the previous 3 years.

Evaluation and Management Codes (E/M)

99202	**New** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **straightforward** medical decision making Time spent on the calendar date of encounter **15-29 minutes**
99203	**New** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **low-level** medical decision making. Time spent on the calendar date of encounter **30-44 minutes**
99204	**New** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **moderate-level** medical decision making Time spent on the calendar date of encounter **45-59 minutes**
99205	**New** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **high –level** medical decision making Time spent on the calendar date of encounter **60-74 minutes**

Evaluation and Management Codes (E/M)

99212 **Established** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **straightforward** medical decision making
Time spent on the calendar date of encounter **10-19 minutes**

99213 **Established** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **low-leve**l medical decision making
Time spent on the calendar date of encounter **20-29 minutes**

99214 **Established** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **moderate-level** medical decision making
Time spent on the calendar date of encounter **30-39 minutes**

99215 **Established** patient office or other outpatient visit which requires a medically appropriate history and/or exam and **high-leve**l medical decision making
Time spent on the calendar date of encounter **40-54 minutes**

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HCPCS – Healthcare Common Procedure Coding System

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Answers the "WHAT and HOW"

Developed by CMS

Collection of standardized codes that represent medical procedures, supplies, products, and services.

Miscellaneous procedures
Medications
Equipment
Supplies

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HCPCS Codes - Maternity Care

Medications
Medications are usually coded from HCPCS Codes
In addition to the HCPCS code, each medication is assigned a National Data Code (NDC)
Every medication must be billed with both the HCPCS code and the NDC
The index is user friendly.

If you administer the medication by injection, there is a CPT Code for it.

RhoGam	full dose	J2790
Injection	CPT Code	90782
Pitocin IU		J2590

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ICD-10 Codes International Classification of Diseases Ed. 10

World Health Organization

Answers the Question "WHY"

World Health Organization (WHO) Classification Index of Every Reported Disease or Injury Scenario in the World

Update October 1 every year

Separated into 21 sections

Each section preceded by guidelines

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ICD-10 Categories

1. AOO-B99 Certain Infectious and Parasitic Diseases
2. COO-D49 Neoplasms
3. D50-D89 Diseases of the Blood, Blood Forming Organs, and Certain Disorders of Immune Mechanism
4. E00-E89 Endocrine Nutritional and Metabolic Diseases
5. F01-F99 Mental, Behavioral and Neurodevelopment Disorders
6. G00-G99 Diseases of the Nervous System
7. H00-H59 Diseases of the Eye and Adnexa
8. H60-95 Diseases of the Ear and Mastoid Process
9. I00-I99 Diseases of the Circulatory System.
10. J00-J99 Diseases of the Respiratory System
11. K00-K95 Diseases of the Digestive System
12. L00-L99 Diseases of Skin and Subcutaneous System
13. M00-M99 Diseases of the musculoskeletal system and connective tissue
14. N00-N99 Diseases of the Genitourinary System

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ICD-10 Categories - cont.

15. O00-O9A Pregnancy, Childbirth and the Puerperium
16. P00-P96 Certain Conditions Originating in the Perinatal Period
17. Q00-Q99 Congenital Malformations, and Chromosomal Abnormalities
18. R00-R99 Symptoms, Signs, and Abnormal Clinical and Lab Findings, Not Elsewhere Classified
19. S00-T88 Injury, Poisoning, and Certain Other Consequences of External Causes
20. V00-Y99 External Causes of Morbidity
21. Z00-Z99 Factors Influencing Health Status and Contact with Health Services

Each code has guidelines that rule specificity.

Your EMR should be loaded with all ICD-10 codes. There are too many codes and variations of specificity to memorize codes.

The EMR index should allow for choosing from family of codes that indicate specificity.

Pregnancy codes often require coding for trimester.

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Choosing the Best Diagnosis Code

Who assigns diagnosis code?
Only the Provider is permitted to assign the ICD-10 code on all encounters.
The diagnosis code reflects an assessment and is used to develop a plan of are for the patient.

What happens if there is an error in the choice of the diagnosis code?
Only the provider is permitted to correct or change the diagnosis code. It should always be changed in the chart.

A certified coder can discuss the diagnosis code and alert the provider as to the sequence and additional reporting rules, but they cannot recommend specific codes.

A provider can leave standing orders that include ICD-10 codes by which a certified coder may post, but again only a provider can assign a diagnosis.

How many codes can you list?

Claim forms can accept 12 diagnosis codes per claim

How to Search for Diagnoses on a Drop-Down Menu

Varies from EHR Brand as to Setup
Organized in Keywords

Examples

Encounter for supervision pregnancy
Complications of labor
Ectopic
Preeclampsia
Excision
Encounter for general adult medical exam
Postpartum
Delivery
Prolonged 1 stage
Incision

You will be taken to an area where there are many codes that are categorized to further indicate specificity.

Some codes ask for trimester, weeks gestation, age, before delivery, after delivery, cause, as part of specificity choices.

ICD-10 Coding Sequencing Guidelines

It is important for ICD-10 Codes to be listed in the order of priority according to CMS guidelines.

Obstetric problems require ICD-10 from Chapter 15, with codes ranging from O00-O9A
Other codes from other chapters may then be used to include specificity
Obstetric codes may only be used on the maternal record, never on newborn

First-listed codes
Obstetric codes are always **listed first** in the sequence of codes.
Usually has a last digit included that describes trimester, but not if only occurs in a certain trimester
A status code from the "Z3A" series that indicates gestations week completed **following first-listed**
Example: Z3A.18 Gestational age 18 weeks
Never a first-listed code, but always following other codes
Routine prenatal visits without complications present, coded from Category "Z34" series as a first-listed diagnosis. **Do not code** any Obstetric Code in conjunction with it.

Pregnancy Incidental to the Visit
"Z33.1" Pregnant state incidental used in place of any obstetric (O) codes. The provider then codes for the condition that was the reason for the encounter.

Principal or First-Listed Diagnosis

Supervision of high-risk pregnancy **Episodes when no delivery occurs**	Code category O09 used only for prenatal period Code principal complication which necessitated visit. If more than one exists, monitored or treated, any may be coded first, but typically the most serious.
Episodes when a delivery occurs **Birth Center, Home**	No complications, Code O80 Complications-Code the most serious one from O codes Add additional codes specific to other complications.
Outcome Codes	You must include a status Z37 code to report the outcome of delivery **Not ever first-listed. Maternal record only** Z37.0 Single live birth — Z37.2 Twins, both liveborn Z37.1 Single, stillbirth — Additional multiple codes

Pre-existing conditions to pregnancy vs conditions of pregnancy
Codes will specify in definition
Codes that do not distinguish, may be used for either

Principal or First-listed Diagnosis - cont.

Gestational (pregnancy induced) diabetes	Codes from Subcategory O24.4 (No other code from O24 may be used in pregnancy) Pregnancy, Childbirth, Puerperium includes diet controlled, insulin controlled, and controlled by oral hypoglycemic drugs Code appropriate code for control method
Abnormal glucose tolerance in pregnancy	Subcategory O99.81 Abnormal glucose complicating pregnancy, childbirth, puerperium
Puerperal sepsis	Category O85 Assign secondary code to identify causal organism
Infections in general	Assign primary code, list secondary causal organism if known

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Labor Management and Delivery

Documentation

2027

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Documenting Labor and Delivery Best Practices

- Document flow of labor, including correct Date of Service, Time, and all relevant information. Follow timeline of your protocols and include patient activity.
- Document vitals signs according to labor protocol, void, s/s to report, any cervical exam data, FHT, position.
- Document medication rationale for use, dosage and route of entry. Document Lot #, consent, results.
- Document any complementary therapies used, rationale for use, dosage, route of entry, consent, results. Document time in and out of tub for hydrotherapy.
- Each encounter must stand on its own and provider should sign each note. If an assistant is also charting, the provider should countersign following the assistant's signature. Indicates provider reviewed.

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Documenting Labor and Delivery Best Practices - cont.

- Utilize electronic devices to assist with time keeping and keeping track of noteworthy events including specifics surrounding the delivery of the baby.
- Birth assistant should document the presence of the provider. "Melissa is at the bedside."
- Provider should document consent every time any vaginal exams or procedures performed. Assistants should document witness of such.
- Following the completion of the delivery, the provider should complete a labor and delivery summary, including all pertinent info involving course of labor, ROM, medications, any maneuvers necessary, postpartum course, EBL, wound repair and plan of care. Procedures should have a separate note documenting specifics as appropriate for whatever was performed, including any relevant supplies.
- Transport Summary prepared, if transfer is indicated.

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Labor Management Phase

- Labor management begins when the patient is considered in labor with the “intent to result in delivery.”
- The issue of “intent” is integral to the definition and whether this period of care will be considered labor management OR an antepartum period of observation.
- Documentation upon initiation of care should include that the provider anticipates that labor will progress towards delivery.
- Whether labor ultimately results in delivery on that date of service, is immaterial.
- Should the pregnant person go home after it is determined that they remain in the latent phase and return on a different date of service, the initial labor management day starts anew, with similar documentation of “intent.”

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“Consensus Guidelines for Intermittent Auscultation in the United States Community Birth Setting”

Birth/Volume 53, Issue 1 pp.100-107

Silke Akerson, Sarah Bradbury, Rosana Davis, Wendy Gordon, Amy Romano, Holly Scholles

Published July 4, 2025

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Documentation Elements for FHT Reporting

"Comprehensive assessment and documentation of FHT in labor should include:

- Fetal heart rate in beats per minute as a single number or a range of (e.g., 128 or136-144).
- Baseline heart rate with parental heart rate
- Presence or absence of accelerations
- Presence or absence of decelerations
- Presence or absence or arrhythmia
- Assessment and plan for any changes or concerns related to FHT

Some midwives may also include variation in their documentation."

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Shared Decision Making

Document any discussions and confirmation of understanding on part of patient and family related to shared decision making regarding course of care, treatments, transport.

Consents and Waivers
These should be obtained in writing whenever possible. Verbal consents should be documented and witnessed by another party (staff, family member).

Date and Time of Signature

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Degree of Risk

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Levels of Labor Management

Straightforward

If **ALL** of the following are not met, refer to complex management:

- Singleton, vertex presentation
- Routine fetal monitoring
- Fetal monitoring (e.g. fetal heart rate) not requiring provider intervention
- Normal progression of labor including induction or augmentation
- Stable medical conditions (e.g. well controlled hypertension, diet-controlled diabetes) not requiring additional management in labor
- No previous cesarean delivery

Complex

If any of the above criteria is not met, report Complex

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Element 7: Assignment of CPT, HCPCS, ICD-10 Codes

Why

Every encounter must have applicable codes assigned to each E/M code, any procedures, supplies, injections, immunizations, etc.

Every CPT or HCPCS code must have an ICD-10 code to identify relevant diagnosis(es) to determine medical necessity.

Authentication Is Your Attestation

Authentication is the provider's formal attestation that the documentation is complete, accurate, and represents the services they performed.

- A chart can be written and still not be authenticated.
- A chart can be partially completed and still not be authenticated.
- A chart can have data entered by staff, students, scribes, or templates and still require provider authentication.

Know Your Audience

Who May Review the Patient Record

- Documenting Provider
- Other Providers
- Provider Support Staff
- Patient
- Payer Reviewers
- Auditors
- Attorneys
- Hospital Risk Managers
- Coding and Billing Staff
- Fraud Investigators

The Legal Perspective

Documentation is **Future You** Talking to Someone Else

Future You may be talking to:

- A payer auditor
- A malpractice attorney
- A state board investigator
- A credentialing committee
- A judge
- An expert witness-months or years later.

Element 8: Authentication Requirements

Why

Proper documentation of who rendered the service must be included on every encounter. Not documented, not done. Must also include date of service and with EMRs, they often include a time stamp.

What

Some format of the provider signature that is secure and cannot be altered in any manner. No one may authenticate the chart except for the provider. There are strict federal laws that can lead to investigations, if there are red flags in a patient's record.
EMRs should have security measures that restrict access to authentication options.

Practical Concerns Across Platforms

Common Challenges Seen Across Many Systems

- Charts left open for days or weeks
- Draft notes mistaken for completed notes
- Missing signatures
- Missing provider attribution
- Duplicate template language
- Copy-forward documentation
- Inconsistent time tracking
- Missing linkage between assessment and plan
- Multiple people contributing to one single note without digital signatures to separately identify

These issues exist across virtually every EHR and practice management system. The software may differ. The risk does not.

Resources

Centers for Medicare and Medicaid: http://www.cms.gov/

American Association of Professional Coders: www.aapc.com

American Medical Association: www.ama-assn.org

American College of Obstetricians and Gynecologists: www.acog.org

CMS SDOH Z Code Guide:
https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

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