

Charting for Midwives

Getting Credit For the Work You Do

Moving Beyond S.O.A.P.

The U.S. health care system is moving past fee-for-service billing.

In the future, the providers will be reimbursed based upon quality care and the results demonstrated in their patients.

Every provider will be profiled to determine whether they meet benchmarks that demonstrate the value they add to their patients' care.

The documentation provided will integrate widely in the healthcare system with other providers, hospitals, labs, and pharmacies.

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Midwives and Quality Care

- ▶ Midwives consistently measure high on quality care models.

The preventive and healthy lifestyle emphasis endemic to midwifery care, specifically documented, will reflect good outcomes.

Healthcare is moving more and more into the outpatient setting and back into the home.

This has proven to be safer, more cost-effective and assists providers in more accurately assessing the patient's specific challenges.

Documentation Provides PROOF

- ▶ Did you document it?
- ▶ Can you see that you did it?
- ▶ Does the patient understand it?
- ▶ Can you prove it?

Documentation Paints a Picture

- ▶ Tells a story about patient's condition and care provided
- ▶ Reflects good, quality care to the patient.
- ▶ Helps protect you in the future.
- ▶ Allows you to get the credit for the work done.

Always Document:

- ▶ Stability of patient's condition. If normal, say so and why.
- ▶ Document any complications or underlying conditions that could complicate the patient's condition.
- ▶ Document any medications, herbs, homeopathics, dosages and rationales for their use.
- ▶ Review of any records sought and/or received.
- ▶ Any consultation with any other care provider.
- ▶ Document all relevant diagnoses and their current status.

MEAT

The chart must document that the condition was :

Managed

Evaluated

Assessed

Treated

Medical Necessity

- ▶ The Affordable Care Act places the patient in the driver's seat as to how they want to spend their health care dollars. Always, the patient must be consulted and informed about cost before services are provided.
- ▶ Insurance carriers and Medicaid require that any services billed be considered by THEM to be medically necessary. The provider may consider it medically necessary, but it must meet their approval.

Frequently this comes up with regard to labs and preventive care. Not all preventive care is approved by each insurance carrier.

How the Record Should Be Organized

- ▶ The Center for Medicare and Medicaid has issued guidelines that support Clinical Documentation Improvement initiatives. These have now made Evaluation and Management (E/M) services organized to follow these guidelines. S.O.A.P. is no longer the preferred charting style.

Electronic Medical Records software have now been organized to document in this other style, and those records can synch into other provider and healthcare systems fairly seamlessly.

- ▶ Midwives will be expected to integrate into the healthcare system too. It is important to mirror charting templates to that which all other practices are doing so as to allow for quick review of critical information, and to demonstrate proficiency in charting. This is important since it is part of your professional presentation.

The Evaluation and Management Services

- ▶ E/M visits cover prenatal appts. and the charting guidelines would apply to every visit during the pregnancy.
- ▶ All E/M visits have the following elements: H-E-M
 - History
 - Exam
 - Medical Decision Making

Without all elements, you don't really have a complete prenatal appt.

The History

The history is the patient's story. This is really the information contained in the "S" of SOAP.

The history has 3 elements:

- History of Present Illness

- Review of Systems

- Past Medical, Family, Social History

History of Present Illness (HPI)

Chief Complaint:

Why is the patient here today? This should be in their words.

Document any of the following elements that are relevant to today's visit:

Location-be specific, i.e., RUQ, lower back, foot and ankle edema

Quality-status of condition, i.e. feeling well, feeling bad, improved, worsened, stable, etc.

Duration-How long has this been going on?

Timing-is there a pattern?, i.e. "abdominal 3 times this week"

Severity-Specific measurement, i.e. BP, Glucose, Kick counts pain scale.

Context-Is there information that could provide further details or context.

Modifying factors-Any actions the patient has taken to help situation, i.e., take remedies, take prenatal vitamins, went to Dr., took herbals, etc.

Associated Signs and Symptoms-I have a stomach ache, and also nausea and vomiting.

Review of Systems (ROS)

Further defines any of the symptoms mentioned in the HPI

Ask questions about any body areas or systems that are relevant to what was revealed in the HPI.

Constitutional-general symptoms, i.e. fever, weight gain, tired

ENT	Eyes	Cardiovascular
Skin/Breasts	Respiratory	Endocrine
Gastrointestinal	Genitourinary	Musculoskeletal
Neuro	Psych	Heme/Lymph
Allergy/Immuno		

Charting should read: Client states/ Client denies and then list the symptoms relevant. Do not ask about a body system if there is no reason.

Past Medical, Family and Social History (PFSH)

All new OB interviews should include obtaining of past medical, surgical, family and social history.

During subsequent visits, revisiting these elements are important when relevant to the purpose of the appt.

If the woman is young, low-risk, no need to reference and chart her family history at each visit.

Electronic medical record software allows you to pull this over from previous visits.
DON'T DO IT!!!

If you ever file insurance, this has negative ramifications and so don't get into the bad habit of it now.

The Exam

After listening and investigating the history, the provider should perform an exam on the body areas or systems that are relevant to today's appt.

Be thorough, but do not check systems that have no bearing on the purpose of the day's visit. Remember the medical necessity principle.

Document all findings very specifically including location, size, color.

No touch exams: exams performed without any touching. Getting to be a new trend. Don't do it—demonstrates lazy practice. Not in the best interest of the patient.

Telemedicine is becoming more popular in rural areas, but that service has specific guidelines and billing policies. It is not appropriate for midwives.

The Exam is the "O" in S.O.A.P.

Documenting Labor Exams

Labor records are exams-document accordingly.

During labor checks, document all relevant issues. When documenting FHTs, be very thorough. Include evidence of assessment of variability.

Be as specific about time as you can. If there are gaps in record keeping, document the reason, i.e., sleeping.

If you make an assessment based upon your exam, document rationale for what course of action you will take.

Document thoroughly discussions involving informed consent and client responses.

If you consult in labor, document what was recommended. Make sure you document the date and time you consulted.

Medical Decision Making (MDM)

The Medical Decision Making (MDM) is the A and P in S.O.A.P.

Document all the complexities and assessments considered in the evaluation of all that was considered in the History and Exam.

Document all diagnoses and assessments. Document the complexity of the findings. If the woman is healthy, document stability and good health.

Document any review of data or records, consultations requested, or tests ordered.

Document risk of complications, morbidity, and mortality. Document responses from the patient.

Document recommendations specifically. Do not leave anything out.

Medical Decision Making

After you have documented your assessment and plan, review the record. Refer back to the “chief complaint” and see if you evaluated the reason they said they came for care.

Make sure that your Assessment and Plan reflects the medical necessity component.

Make sure that your documentation makes sense if read by a third party.

Your documentation should answer the questions, what, where, when, why, and how, if relevant. Don't leave gaps.

Counseling and Education

Time based services have specific requirements that must be recognized. If greater than 50% of the visit was spent counseling or teaching, state this.

When counseling or providing education to patients, you should state what time this part of the appt. began and when it ended. When billing for these services, that element is required.

Document what was counseled or discussed.

Document the client/patient's response.

Document next steps.

Putting It All Together

The note must stand alone. Everything that a third-party reader may need to know about this patient encounter, must be documented in the current record associated with that day's visit.

Don't refer to any other date's record. Keep it all in the current visit.

Do not use alphabet acronyms in your documentation.

Always sign your record and date it.

Do not use terms like “non-contributory,” “all are negative”, “all normal.”

Use the appropriate medical terminology, and **CHECK SPELLING!**

The Nine “Cs” of Clinical Documentation Improvement

1. Clarity
2. Consistency
3. Completeness
4. Cohesion
5. Coder Friendliness
6. Concision
7. Compartmentalization
8. Cleanliness
9. Credibility

* Camilleis, Ken, Industry News, American Association of Professional Coders, April, 2016.