American Academy of Dermatology Association
Approved: Board of Directors: 10/23/14
Revised: Board of Directors: 11/6/21

Documentation of Patient Encounters and Procedures

The American Academy of Dermatology Association (AADA) believes documentation, charting and record-keeping are integral elements of effective 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.

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. Documentation must be viewed in the context of prior and future chart notes, the physician's typical practice, and any particular guidelines the physician maintains as standard operating procedures (SOP). 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.

Elements that are relevant for patient care and necessary to understand the nature and complexity of the encounter as well as the details of procedures performed are generally included in effective and efficient documentation.

1. For evaluation and management services, documentation should include an explanation of the patient visit, including: its purpose or reason, a patient history and physical examination descriptions if deemed relevant, a description of the problem(s) addressed as well as specific variabilities (patient comorbidities, disease severity, etc.) that impact the complexity of the condition and plan of care, actions taken and/or medical decision making performed, and any other pertinent information. Data reviewed and analyzed should be documented including test(s) ordered, reviewed, and/or interpreted. Alternative sources of history or discussion should be documented including those with an independent historian and discussion(s) with other medical providers. Time spent in the context of the encounter must be included when the level of E/M services is based on time

2. For procedures and surgeries, documentation should include a diagnosis, the indication for the procedure if not self-evident, notation of informed consent provided/obtained, documentation of the procedure, including the unique aspects of each procedure such as location, size, suture type, along with any anatomic or morphologic specifics, and patient disposition if other than home.

3. Certain practices and procedures are redundant in the medical record and may be referred to as standard procedure or SOPs. For example, instead of noting exactly how a patient is prepared for surgery the record may reflect that the patient was prepped for surgery in the usual fashion. In such cases they may choose to maintain a separate document listing these SOPs and refer to these when they apply. Internal and external review of chart documentation should be viewed in conjunction with relevant SOPs, if they exist.

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.

Certain elements are of **lesser use and relevance for patient care and may not be included** in effective documentation of patient encounters and procedures, as described below.

1. Patient encounters that include evaluation and management documentation should focus on necessary / relevant information and not on duplicative data that is recorded and reviewed elsewhere in the medical record. Medical record 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 of information from note to note. When previous patient-relevant information is reviewed, notation of the review of that information should be indicated in the documentation of the encounter.

2. 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 information may 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 changes should be incorporated as appropriate.

3. Procedures should be documented in the most clear and concise method. Procedural details that are standard and reproducible for a physician, may be referred to as standard procedure or SOP or may be duplicated using a MACRO or similar tool in the electronic or written health record. Thus, procedures that are essentially identical from one patient to the next may appropriately appear duplicative and uniform in nature. When procedures deviate from the norm for a particular physician, these deviations should be reflected in the documentation of the procedure.

The AADA strongly supports national policy designed to improve access to high quality 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 and relevant information regarding a patient encounter and procedure.

NOTES
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.