

Clinical documentation for patient care: Models, concepts, and liability considerations for pharmacists

SEENA ZIERLER-BROWN, TIMOTHY R. BROWN, DAVID CHEN, AND ROBERT WAYNE BLACKBURN

Managed care health systems and payers have acknowledged that pharmacists can provide consistent, cost-effective clinical services that improve patient outcomes and reduce health care expenditures.¹⁻³ In July 2004, the American Society of Health-System Pharmacists (ASHP), along with 10 other national pharmacy organizations, developed a consensus definition that characterized medication therapy management (MTM) as a distinct service or group of services that optimizes therapeutic outcomes for individual patients.⁴ Effective in January 2006, pharmacists were recognized providers of MTM as defined under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Part D prescription drug benefit.⁵ It has been clearly recognized that collaborative MTM can maximize patients' health-related quality of life (HRQOL) and reduce the frequency of preventable drug-related prob-

Purpose. A guide to the appropriate documentation of the critical aspects of the patient medical record to ensure reimbursement and the reduction of medical liability is presented.

Summary. Several documentation styles can be adopted to record pharmacist interventions, including unstructured notes, semistructured notes, and systematic notes. Documentation should be clear, concise, legible, nonjudgmental, patient focused, and standardized, and it should ensure patient confidentiality. Systematic documentation styles include SOAP (subjective, objective, assessment, plan), TITRS (title, introduction, text, recommendation, signature), and FARM (findings, assessment, recommendations or resolutions, management). SOAP is the primary form for which payers traditionally reimburse. Systematic documentation should be used to demonstrate how pharmacist interventions improved patient care and should not just be used for reimbursement. Pharmacists have the opportunity to build a collaborative relationship with other professionals and with patients. Documentation can provide evidence of this symbiotic relationship where the pharmacist assists in providing a

caring and compassionate environment for the patient's benefit. Professional liability, as it relates to clinical documentation, can be an issue. Documentation provides the necessary information to successfully manage the process of discovery and the review of the conduct of all parties involved in a liability issue.

Conclusion. Documentation in a universal format allows for communication among health care practitioners. Written documentation is one key to a successful, open-communication partnership among providers. In addition, accurate, appropriate, and concise documentation is an essential component of ensuring that the patient care provided is evident, not only for patient safety and continuity but also for cases where reimbursement and quality of care are being challenged contractually or legally.

Index terms: Documentation; Interventions; Liability; Medical records; Methodology; Patient care; Patient information; Pharmaceutical care; Pharmaceutical services; Pharmacists; Professional relations; Quality assurance; Reimbursement; Standards

Am J Health-Syst Pharm. 2007; 64:1851-8

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DOI 10.2146/ajhp060682

lems. In this team approach, drug therapy decision-making and management are coordinated through the collaboration of pharmacists, physicians, nurses, and other health care professionals. To participate in collaborative MTM, pharmacists must have access to patients and patient medical records (PMRs). Pharmacists will need to collect data, document care, and provide quality assurance for these activities.⁶

Documentation is a key to providing standards of practice and demonstrable evidence of a pharmacist's contribution to high-quality, coordinated care. Pharmaceutical care is the direct provision of medication-related care for the intention of achieving definite outcomes that improve a patient's health status.⁶ Documentation of pharmacist-provided care in a collaborative MTM service is critical. When pharmacists participate in collaborative MTM, they must document their activities in the PMR. Documentation of care should be made available to other health care professionals in a timely fashion through established channels of communication. Historically, clinical services have been reimbursable in an outpatient sector as incident to a physician's services requiring a complete PMR.⁷ Information contained in a PMR can serve as a legal, permanent health record; an evaluation of clinical drug use; a marker of critical thinking and judgment; a platform for the education of health care professionals; justification for reimbursement; a method to improve continuity of care; and a quality-assurance tool for practice standards.

This article will guide the reader to appropriately document critical aspects of the PMR to ensure reimbursement and to reduce medical liability.

Documentation styles

Several documentation styles can be adopted to record pharmacist interventions, including unstructured

notes, semistructured notes, and systematic records.⁸ Documentation should be clear, concise, legible, nonjudgmental, patient focused, and standardized, and it should ensure patient confidentiality. Systematic documentation styles include SOAP (subjective, objective, assessment, plan), TITRS (title, introduction, text, recommendation, signature), and FARM (findings, assessment, recommendations or resolutions, management). SOAP is an interventionist approach, TITRS is an assessment approach, and FARM places importance on monitoring. SOAP, TITRS, and FARM are good examples of standardized formatting. Each style of structured or unstructured documentation has advantages and disadvantages but should be consistently used in the most effective and efficient manner. Unstructured notes, as the name implies, are free in form with appropriate language and chronology. They can be written expeditiously while still providing a solid, high-quality, general overview. On the contrary, if done poorly, they may be incomplete and inconsistent, offer limited means of communication to other health care professionals, and leave practitioners vulnerable to liability.

Systematic documentation provides completeness, consistency, and organization. Documentation without a systematic structure may be time-consuming and confusing, especially if pharmacists vary the placement of information from different sources. One example involves the placement of a patient's height, weight, and allergies. One clinician may document this information in the subjective field, while another one may place it in the objective field. The primary determinant of placement should be how the information was collected. Was it patient reported (subjective) or clinician measured (objective)?

Semistructured documentation blends these different styles where some fields are more standard-

ized and others are free text. Like systematic documenting, semistructured documentation may also lack the quality and consistency of the standardized SOAP note. Semistructured documentation may be best stratified when triaging or forming a general impression for referral with no specific action by the pharmacist. Structured SOAP notes may be more appropriate when follow-up and monitoring are required and the continuity of a pharmacist provider exists (e.g., in community clinics, health centers, and outpatient pharmacies).

Documenting patient care

SOAP documentation is the primary form for which payers traditionally reimburse. Systematic documentation should be used to demonstrate how pharmacist interventions improved patient care and should not just be used for reimbursement. Documentation should be complete, complementary, compelling with supportive evidence, and standardized and systematic to complement oral communication among providers. Furthermore, documentation should reflect patient agreement with the care plan among multiple providers in terms of medication reconciliation, data collection, continuity of care, and the transitioning of care.^{9,10} Practitioners should focus on treating the patient and not merely interpreting laboratory results.

Approximately 46% of the medication errors in the institutional setting occur during admission or discharge when new orders are requested for patients.⁹ Reconciliation of medications is important in providing institutional care to avoid errors in transcription, omission, duplication of therapy, indication for use, and drug-drug and drug-disease interactions.² A simple example of reconciling medications is comparing the drugs that the patient reports taking at home against a recently documented medication administration record.

Manasse and Thompson's¹¹ review of drug misadventures revealed that up to 4.7% of hospital admissions were linked with adverse drug reactions.

Pharmacists have the opportunity to build a collaborative relationship with other health care professionals and with patients. Documentation can provide evidence of this symbiotic relationship where the pharmacist assists in providing a caring and compassionate environment for the patient's benefit. Patients are responsible for providing their personal information and preferences and action steps in their own care plan. Facilitation of this process involves communication, comprehensive data collection, and attention to HRQOL. The source of information and predicted adherence to medication use should also be considered. Documentation is much more than filling out forms during a patient encounter. No single ideal form can encompass all patient interviews, yet documentation can still provide evidence of the pharmacist's actions and successes in patient management and advocacy.

An example SOAP note (Figure 1) illustrates a standardized, structured approach to documentation and medication reconciliation. Overarching categories of documentation indicators that can serve as a checklist reminder for the documentation of a clinical encounter can be found in the appendix. The four distinctive sections of a SOAP note are outlined as follows:

1. Subjective: symptoms the patient or caregiver verbally expresses. These descriptions provide a clinician with insight into the severity of a patient's condition, the level of dysfunction, the illness progression, and the degree of pain.
2. Objective: measurements that are observed (seen, heard, touched, smelled) by the clinician. Examples include vital signs, pulse, temperature, skin color, edema, and diagnostic testing.
3. Assessment: a prioritized list of assessed patient conditions. This may consist of the level of control, differentials, potential confounders to control, pertinent positive or negative signs and symptoms related to the condition, reference to evidence-based medicine goals, considerations for pharmacotherapy, and adjunctive lifestyle measures.
4. Plan: care plan action steps for the patient and health care practitioners. These steps may include requests for laboratory or diagnostic assessments, alterations in pharmacotherapy, lifestyle recommendations, standards of care, special directions, referrals, self-monitoring, emergency contacts, and time to follow-up appointments.

Additional considerations when documenting patient care can be obtained from the ASHP Guidelines on Documenting Pharmaceutical Care in Patient Medical Records and Guidelines on a Standardized Method for Pharmaceutical Care.^{12,13} In addition, a variety of different documentation templates have been used in practice and are being developed as MTM continues to evolve. For example, a community-based MTM model has been developed under the partnership of several pharmacy organizations and published through the American Pharmacists Association and the National Association of Chain Drug Stores.¹⁴ This framework identifies five core components: medication therapy review, personal medical record, action plan, intervention and referral, and documentation with follow-up. A standardized medication action plan and personal medical record template are provided.

The SOAP note shown is based on a patient-pharmacist interaction in an ambulatory care or primary care facility. In this example, the patient has returned for a follow-up appointment to be assessed by the clinical pharmacist for a half-hour encounter.

Figure 1 shows the note with a combined assessment and plan. Figure 2 shows an alternative approach in which the assessment and plan (to go with the subjective and objective sections of Figure 1) are kept separate. Both are suitable forms of documentation for reimbursement, and they can be left to clinician preference or the documentation procedure specific to the individual practice site. SOAP notes may be kept in an electronic database to expedite data collection, report clinical indicators, and ease documentation for follow-up visits. It is important to note that any other style of structured documentation may also be integrated or the use of an electronic medical record may be preferred, depending on the care setting and practitioner's preference.

Reimbursement for clinical pharmacy services

Current Procedural Terminology (CPT) codes for pharmacists have been approved for the provision of MTM services through the MMA.¹⁵ This will facilitate the opportunity to bill government health programs, managed care organizations, and other payers for a pharmacist's clinical services. CPT codes are published by the American Medical Association with the intent to be used for the systematic listing and coding of medical, surgical, and diagnostic procedures and services.¹⁶ The CPT coding for pharmacists (category III 0115T, 0116T, and 0117T) is temporarily approved for five years and acknowledges the allocation of time in an initial encounter, follow-up visits, and appointments exceeding 15 minutes in duration. These pharmacist-specific CPT codes came into effect January 2006. In years past, pharmacists who were under collaborative practice agreements used the CPT counseling code series 99211–99215 (levels I–IV) for the assessment and management of newly referred and established patients “incident to” the

Figure 1. Example of a SOAP note with a successional assessment and plan.

Pharmacotherapy Office Visit:

Date: 10/15/06

S: ML is a 69 YO AAF who presents for follow-up of type 2 DM, stage 2 HTN, recent stent placement, and GERD. Family reports pt is out of clopidogrel as of today. Pt has not been seen in medical clinic since 2/17/06. Pt admits to not using her BP meds since they make her dizzy and she feels her constant HA is due to the drugs. Pt also admits to dosing her insulin as she wants, secondary to not understanding the instructions her PCP gave her on last visit.

PmHx:

GERD

Type 2 DM x 20 yr

HTN x 20 yr

Gallbladder disease

MI and S/P stent in 1/06

ROS/PE

DM: no polydipsia, polyphagia, or polyuria. (-) Episodes of hypoglycemia since last visit. (-) Tingling, burning, or numbness of extremities. Nocturia x 2-3.

FBG: per family, ranging 150-180 mg/dL.

HTN: slight HA with dizziness; no SOB, cough, CP, palp, N/V/C/D, edema.

GERD: (-) regurgitation, (-) heartburn.

SocHx:

Diet: trying to follow a low-fat, low-CHO diet with limited success.

Exercise: laundry and house cleaning once or twice a week (>30 min).

(-) Etoh.

(+) Tob (pack in a week).

ALL:

NKDA.

Immunizations:

None documented.

O: Sex: female; height: 5'1"; weight: 186; race: African American; BMI: 34; temp: 99.1; BP: 178/88-RA; recheck 150/80; P: 96; RR: 18; pain: 3/10.

FBG: 162 this AM.

Previous FBG: 167, 225, 357, 333.

laboratory (3/1/06):

Na 136 Cl 99 BUN 15 Gluc 173l

K 4.1 CO₂ 25SCr 1.1

Hgb 10.1

Hct 32

WBC 5.2

Plt 194

HbA_{1c}: 8.6%.

LFT: WNL.

FLP: pt did not have drawn.

Microalbumin: not collected.

Medication history:

Novolog, 70/30 32 units Q AM and 11 units Q PM (currently using 20/15 units).

Metoprolol, 50 mg 1/2 tab PO daily.

Clopidogrel, 75 mg PO daily.

Omeprazole, 20 mg PO BID.

HCTZ, 25 mg 1/2 tab PO daily.

Lisinopril, 20 mg PO daily.

OTC and herbals:

None.

A/P:

- DM: continues to be uncontrolled based on last FBG and recent HbA_{1c}. Pt has not been seen since 2/06. She has been using Novolog 70/30 and Actos 30 mg daily. Pt was unsure of prescribed units for Novolog and has been using 20 units Q AM and 15 units Q PM. Will titrate insulin back to prescribed dose per PCP. She is to increase the morning dose to 35 units and maintain the 15 units in the evening. Will also increase pioglitazone to 45 mg daily. Pt is to keep BG log and present it on next visit to office in 2 weeks. Will order HbA_{1c} once doses stable for 3 months. Signs and symptoms of hypoglycemia were discussed and pt to call office if she experiences any of these problems. Will also need referral for standards of care with podiatry, dentistry, and optometry. (FBG goal 90-130, <126 mg/dL, PPBG <180 mg/dL; HbA_{1c} <6-7%.)
- HTN: uncontrolled, possibly secondary to noncompliance with medications and misinterpretation of PCP instructions. Will restart lisinopril 20 mg daily, HCTZ 12.5 mg daily, and metoprolol 25 mg daily. Counseled pt on importance of taking these medications not only for her BP but for her heart and kidneys. BP recheck on next visit to office in two weeks. If BP remains elevated, will titrate ACE-I and diuretic dose. Once dose stable will change to combination product to help with compliance issues. (Goal of <130/80 DM.)
- Hyperlipidemia: no current labs. Pt to have FLP done before next office visit. Will review results with pt at that time. Anticipate initiation of statin therapy since pt has h/o DM2 and CV disease; however, will await LDL to determine dose needed to achieve goal. (Goal LDL <70 mg/dL, TC <200 mg/dL, HDL >40 mg/dL, TG <150 mg/dL).
- S/P stent placement: pt's clopidogrel 75 mg daily refilled. Also, ASA 81 mg daily was started. Pt is approximately 8 mo out from placement.
- Anticipate 9 mo to 1 yr of clopidogrel treatment, then D/C and continue ASA as monotherapy. Will await cardiology input and f/u 12/06.
- Immunizations: will discuss need for pneumovax with PCP. At this time will order influenza vaccine since pt considered high risk and she has no allergies.

Figure 1. (continued)

7. GERD: controlled, will ask pt to use omeprazole 40 mg daily to reduce number of times per day she has to use product. This is being done in hopes of increasing compliance.
8. Written instructions regarding all her medications were provided; however, possibly pt is low-literate. Will discuss with family as well and have them review medications with pt too.
9. Follow-up standards of care needed:
 1. Podiatry (q 6 months).
 2. Dentistry (q 6 months).
 3. Optometry (q 6 months).
 4. Nutrition (prn).

Pharmacist signature

Figure 2. Separate assessment and plan for SOAP note illustrated in Figure 1.

A: DM: uncontrolled based on last FBG and recent HbA_{1c}. Blood glucose has improved since last visit. Pt has not been seen in clinic for 6 weeks and some documentation of night clinic is absent from her chart. She has been on insulin for several yr due to long-standing history of diabetes. Pt taking incorrect units of insulin based on last documented recommendation and will need to be slowly titrated for adequate control. Patient will need the following immunizations: annual flu shot and one-time pneumococcal vaccination. Will also need referral for standards of care with podiatry and optometry. (FBG goal 90-130, <126 mg/dL, PPBG <180 mg/dL, HbA_{1c} <6-7%.)

HTN: uncontrolled; however, pt was very winded from climbing stairs for office visit and did not take medication this AM. Also, pt has not been taking ACE-I and diuretic since last seen in pharmacotherapy clinic because of misinterpretation of physician instructions (language barrier). Antihypertensives were initiated on initial consult in pharmacotherapy clinic. Will need to increase BB dose as tolerated to target dose for S/P MI. Clopidogrel to be continued for up to 1 year S/P MI per PCI CURE study. (Goal of <130/80 DM.)

Lipids: control cannot be determined without fasting lipid blood work. Likely elevated because of previous MI and necessity of stent placement. Pt will benefit from statin initiation due to history of long-standing diabetes (Heart Protection Study). Will request baseline lipids as soon as possible for statin initiation. (Goal LDL <70 mg/dL, TC <200 mg/dL, HDL >40 mg/dL, TG <150 mg/dL.)

GERD: controlled based on resolution of S/sx. (-) Heartburn, regurgitation, burning (-) alarm symptoms of sudden weight loss, dysphagia, or vomiting. Pt has not received endoscopy at this time. Will monitor for tolerance to H₂RA requiring use of PPI for step-up acid control.

P:

1. Increase novolin 70/30 to 22 units Q AM and 16 units Q PM. Substitute atenolol for metoprolol at 50 mg PO daily since metoprolol not available in clinic. Reinitiate lisinopril 20 mg PO daily and HCTZ 25 mg 1/2 tab PO Q AM.
2. Rerequesting clopidogrel through drug assistance as pt has finished supply today. Continue current dose of ranitidine since 150 mg PO daily.
3. Will initiate statin therapy pending results of fasting blood work. Encourage low fat, low chol, low NA diet. Discussed lowering intake of tortillas, beans, and rice, and increase skinless meats and fresh vegetables.
4. Exercise as tolerated since pt is easily winded.
5. Discussed the s/sx of hypo/hyperglycemia and what to do should they occur. Discussed the importance of checking BG BID and bring log when RTC.
6. Caregiver to call clinic with any problems.
7. RTC in one week for fasting blood work to include lipids and metabolic profile. A_{1c} will be reevaluated in 3 months. F/U appt scheduled in 2 weeks on X/XX/XX at 9:30 AM for DM, HTN, and cholesterol. Will titrate insulin and diuretic when RTC.
8. Request flu shot when pt RTC and encouraged to take ASA 325 mg PO daily in absence of clopidogrel and history of diabetes/post-MI.
9. Written instructions regarding medications provided in native language.

Follow-up standards of care:

1. Podiatry (q 6 months).
2. Dentistry (q 6 months).
3. Optometry (q 6 months).
4. Nutrition (prn).
5. Labs needed: lipids, CMP.

Pharmacist signature

physician (onsite) through managed care organizations and under Medicare Part B.⁷

In facility fee models, the billing documentation begins as a 99211 and a facility revenue code where it is part of an Ambulatory Payment Classification that accounts for the facility fee compensation. This is subsequently submitted to the Part A intermediary for payment under the hospital outpatient prospective payment system, which follows the Part B rules. Supported claims require evidence of the following: a medical history review, a description of the chief complaint or reason for the visit, a medication profile including prescription and nonprescription medicine, drug therapy recommendations, and the expected level of adherence to therapy. In order to bill at a higher level beyond a 99211 (level I), the following information must be documented:

Level II (99212):

Problem-focused history of present illness (HPI).

Does not require review of systems (ROS), social history, family history, or past medical history.

Level III (99213):

Expanded problem-focused history.

HPI has one to three elements, and ROS has at least four medications.

Level IV (99214):

Expanded problem-focused history.

HPI has four elements, and ROS has two to nine systems with pertinent family history and social history.

The aforementioned SOAP note can be billed at a level II or III, “incident to” a physician. It should be noted that not all payers recognize pharmacists as having the ability to bill above a level I (i.e., above 99211); therefore, it is important that phar-

macists check with their intermediary or billing specialists to determine what a particular payer’s rules are.

Documentation and professional liability

Professional liability, as it relates to clinical documentation, can be an issue when (1) payment challenge is ensuing for services rendered or not rendered to a patient (billing fraud audits) or (2) legal action is ensuing as a result of an action or inaction by or on behalf of the provider (practice liability cases). In both cases, documentation provides the necessary information to successfully manage the process of discovery and the review of the conduct of all parties involved.

Billing fraud as defined by the Centers for Medicare and Medicaid Services (CMS) is “the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person” or “to purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.”¹⁷ Because there are practitioners that commit billing fraud, CMS has implemented a number of programs to identify and prevent fraud. It is important that pharmacists communicate with their billing specialists to make sure that they are compliant with accepted billing practices and are coordinating their activities with their practice peers. In addition, it is important that pharmacists understand which services are covered under a particular CPT code or were covered under other CPT codes for a particular patient. This knowledge will help avoid the risk of fraud by unbundling and upcoding. Unbundling is the situation where a particular service is billed with multiple CPT codes, but an existing single CPT code would have

covered the services. Upcoding is when a provider bills for a level of service higher than was warranted for the care that was provided (e.g., a level III clinic visit versus a level II clinic visit).

Proper documentation can help defend a provider’s actions when a question of fraud is raised. The issue of billing fraud is a serious problem in the U.S. health system, and some of the more common fraud schemes seen within the Medicaid system that pharmacists should be aware of are¹⁸

- Billing for medical services or goods that were not provided,
- Billing for more hours than there are in a day,
- Overcharging for health care services or goods that were provided,
- Using false credentials, and
- Double billing for health care services or goods that were provided.

Practice liability has increased with the additional responsibility pharmacists have accepted as drug information experts and as their role as nonphysician clinicians has expanded. The scope of professional liability has increased with the pharmacist’s expanding role in health care. Historically, pharmacists had limited exposure under the learned intermediary doctrine when dispensing prescriptions and providing patient care. Many court cases and interpretations of individual state laws supported this limited exposure. The learned intermediary doctrine, which describes the “duty to warn,” had been applied to the scenario of filling and dispensing prescriptions and the professional practices associated with this function. The interpretation of liability that was conferred to the pharmacist lacked the personal familiarity with the PMR, compared with the familiarity the physician and nonphysician clinician (NPC) had, and was such that the pharmacist was relieved of the legal responsibility for

the duty to warn against adverse drug effects or other untoward outcomes related to the medication management of the patient.¹⁹ However, in cases where a prescription had clearly been filled in error, case law indicated that the duty to warn did indeed rest with the dispensing pharmacist.¹⁹

With the paradigm shift of pharmacists providing care directly to patients “incident to” physicians, the responsibility of the pharmacist as a medication therapy expert significantly increases. The shift toward increasing liability and accountability for the pharmacist makes documentation of care essential. As pharmacists continue to expand their role in response to the increasing need for quality and coordinated care in the United States, and as the number of pharmacists providing direct patient care grows, the profession is becoming acutely aware of the risk on a daily basis. Pharmacists should also appreciate the additional scope of risk that physicians assume when collaborating with pharmacists, nurse practitioners, and other NPCs.

In our current legal system, if the patient’s chart does not contain appropriate documentation that care was given or an intervention was made, it can be assumed that the action never occurred. This applies to reimbursement and litigation. Furthermore, if documentation indicates that an NPC provided services beyond his or her capabilities or privileges, took inadequate patient histories, failed to consult with his or her supervising physician, followed protocols incorrectly, or improperly ordered tests or medications, there can be serious implications for the supervising physician. These examples are among the leading causes for NPCs to become involved in litigation.²⁰

In the past, pharmacists’ documentation served to record medication use, interactions, and adverse drug events. Now this documentation has expanded to show the care

that pharmacists provide as health care practitioners. All documentation should include an assessment of the situation within the realm of care that the pharmacist practices. If pharmacists cannot address an identified problem, there must be documentation of how they involved other health care team members to address the needs of the patient.²⁰ The pharmacist’s care plan must be concise and complete. The ideal documentation includes how the pharmacist affected care, a plan for upcoming visits, and interventions for preventive care. Pharmacists must not overlook their corresponding responsibility to ensure quality care is given to the patient. By communicating clinical insights, actions, and plans for the patient, the pharmacist assists the next member of the care team in providing better quality care, ensuring standards of care, and limiting liability.

Any medical or pharmaceutical care record should be objectively written. Litigation against NPCs, where services were rendered beyond their capabilities or there was failure to consult the appropriate physician, has resulted in legal penalties. The following statement by the American Physician Assurance Corporation illustrates the importance of factual documentation for appropriate medical and pharmaceutical care records: “The purpose of the medical record is to record the patient’s health care story and it should contain only clinically pertinent information.”²¹ According to the Joint Commission’s hospital accreditation standards, “The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the medical course and results, and promote continuity among healthcare providers.”

Quality assurance of documentation should be part of pharmacy practice, and considerations that should be reviewed with the patient

care team when documenting patient care and conducting peer review of medical records are the following²¹:

- Placement of blame, finger-pointing, and conflicts and arguments with other caregivers should be resolved through the quality-improvement process; they do not belong in the medical record.
- Subjective accusatory terms should be avoided. Physicians and NPCs must be careful not to let their frustration with another caregiver—or their subjective opinions—be used against them in a lawsuit.
- Concerns about a hospital’s staff, facilities, or equipment should be addressed to the hospital’s administration or department head and, if necessary, described in an incident report.
- Incident reports may be protected from discovery if they are part of a hospital’s peer-review process, though this protection can be challenged by plaintiff attorneys when they become aware of the existence of an incident report. This information can be discovered through a review of the medical record.
- Conversations with an insurance carrier, attorney, or the hospital’s risk manager should not be documented in the medical record. If it is thought necessary to document such conversations, it should be done separately.

Documentation of care requires a systematic objective approach that, if performed judiciously, can provide opportunities for reimbursement while limiting liability. Pharmacists providing expanded MTM services “incident to” physician’s offices should tailor their documentation to the billing, legal structure, and practice preferences of the type of business in which they manage patients. Any documentation of an accusatory nature may be subpoenaed by attorneys and should therefore be avoided.

Conclusion

Documentation in a universal

format allows for communication among health care practitioners. Written documentation is one key to a successful, open-communication partnership among providers. In addition, accurate, appropriate, and concise documentation is an essential component of ensuring that the patient care provided is evident, not only for patient safety and continuity but also for cases where reimbursement and quality of care are being challenged contractually or legally.

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Appendix—Items for documentation in a patient medical record

- Chronological marker
 - Date and time
- Summary of medical history
 - Chief complaint (CC)
 - History of present illness (HPI)
 - Past medical history (PMHx)
 - Social history (SocHx)
 - Family history (FamHx)
 - Surgical history (SurgHx)
 - Allergies or reactions (ALL)
 - Medications, OTC drugs, or herbal medications
 - Review of systems and physical examination (ROS/PE)
 - Laboratory values and diagnostic procedures
- Oral and written consultations
 - From other health care professionals (HCPs)
- Oral and written orders
 - From physician or other HCPs
 - Start and stop dates
 - Precautions
 - Drug interactions
 - Protocols
- Medication changes
 - Adjustment of dose, route, frequency, or form
 - Intended use
- Drug-related problems
 - Actual and potential
 - Drug–drug, drug–food, drug–laboratory, or drug–disease interactions
- Assessment and plan
 - Interventions and professional judgment
- Therapeutic monitoring
 - Rule out duplication
 - Expected adherence
 - Pharmacokinetics
 - Adverse events and toxicity
 - Clinical resolution and symptomatology
- Patient education
 - Therapy related
 - Adjunctive measures
 - Self-monitoring
 - Etiology and progression of disease
- Identifiers
 - Persons involved in patient care
 - Documenting pharmacist
- Aesthetics
 - Indelible ink
 - Nonalterable (electronic)
- Policies
 - Code of ethics
 - Health Insurance Portability and Accountability Act
- Reimbursement
 - Current Procedural Terminology codes: 0115T, 0116T, 0117T
 - International Classification of Diseases, 9th Revision
 - Time spent and rate of service
 - Medicare standards for evaluation and management