All health care providers, regardless of setting, are required to maintain all patient care information that applies to an individual patient.

**Terminology**

- **APC**: ICD-9-CM and CPT codes used for reimbursement in outpatient setting
- **CPT**: Listing of medical terms and codes for diagnostic and therapeutic procedures used for coding for physician reimbursement (used for both inpatient and outpatient)
- **ICD-9-CM**: Universal classification system used in the US and world for coding procedures and diagnoses
- **DRG**: Categorizes into payment groups patients who are medically related with respect to diagnosis and treatment with regard to length of stay
Patient History

Terminology

TJC: organization that accredits hospitals and other health care institutions in the United States (formally JCAHO)

PPS: system for Medicare hospital inpatients whereby payment groups are established in advance; hospitals get paid up front

CMMS: Center for Medicare and Medicaid (most reimbursements)

Health Insurance Portability and Accountability Act 1996

HIPAA clearly outlines the confidentiality requirements of health records

According to TJC

A medical record must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote the continuity of care among health care providers

According to Medicare

The medical record must contain information to justify the admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to the medication and services
Patient History

All departments that take part in the care of a patient must document that care in the healthcare record.

Documenting in the patient’s record, or charting, should be done by radiologists and radiographers when a patient receives either diagnostic or therapeutic radiologic services.

Patient History

- Patient ID and demographics
- Medical history
- Conclusion and impression on admission
- Diagnostic and therapeutic orders
- Clinical observations
- Report of relevant physical exam
- Consultation reports
- Diagnostic and therapeutic reports
- Final diagnosis and prognosis
- Discharge summary
- Postmortem results
- Psychologic needs summary
- Physical exam report
- Treatment plan
- Evidence of informed consents
- Progress notes
- Reports of surgical and invasive procedures
- Records of donations and implants
- Conclusions at termination of stay
- Discharge info given to patient and family

Patient History

Interview of the patient

The RT is the eyes, ears, and mouth of the radiologist.

Possessing good history-taking skills is an essential responsibility.

Information must be accurate and specific in detail.

Genuine interest, attentiveness, and professional competence.

Instill patients with a sense of caring.
Patient History

Most patients understand the importance of a history
Will provide information as requested
Information needed is specific to the reason for the exam
Never disregard what the patient says
Leave your bias out of the interview

Patient History

Documentation:
Charting any permanent notes - part of the patients permanent health record
Paper/pencil/pen
Electronic
Both have signatures
Should be accurate, pertinent, legible

Patient History

Proper Documentation:
Ensures patients are billed accurately
Ensures new supplies are ordered
Insurance companies get correct information for reimbursement
Describes your patient care
Communicates to other health care providers/prevents duplication
Use as a resource for research and records
Poor documentation increases litigation losses
Patient History

Avoid Mistakes:

Subjective vs Objective
To delete an entry – draw one line, date, time, and initial
Late entries – use an arrow, date, time, initial
Do not leave blanks (n/a, -, or Ø)
Identify all papers with patient label (at least the two identifiers) and secure to chart
Date and sign all entries legibly
Course of treatment and quality of care are reflected in your documentation

Patient History

Objective Data
Perceptible to senses
Able to be measured includes VS and labs
Signs that can be seen, heard, felt, and so on

Subjective Data
Patient feelings
Pain level
Attitude
Opinion of observer
Subject to interpretation

Patient History

Use open-ended questions
Facilitate a response from the patient
Remain quiet to get a response
Use probing questions to focus in on more detail
Repeat patient response to clarify and confirm
Summarize to verify accuracy
Patient History

S – signs and symptoms (chief complaint)
A – allergies
M – medications
P – past medical/surgical history and prep
L – last meal/last menstrual period
E – events leading up to this visit

Patient History

Patient Documentation

Used for communication between care providers
Should be a well organized, brief vignette that captures the patient and their clinical problem
Your goal is to help others visualize the patient and understand the problem
No room for sarcasm, judgment, opinions
State facts that are pertinent to the care of the patient

Patient History

Abbreviations

TJC do not use abbreviations
Each facility may have their own list (based on documented errors)
Do not use or accept these terms
Call for clarification
Patient History

Documentation:

- Requisitions (electronic/paper) serve as formal orders to carry out diagnostics
- Contains patient data, may have brief medical history
- Must contain specific instructions
- Every facility will have their own specific policies
- Get to know yours

Patient History

Role of the Radiology Tech

- Act as good listener
- Take accurate notes and record them appropriately
- Essential responsibility of technologist
- Get answers to key clinical questions
- Present a professional image
- Important role in interacting with patient

Patient History

Diagnostic Images as Records

- Whether x-rays are films or electronic – they are part of the medical record
- Belong to the institution
- Patients may believe they own them since they posed and paid for them – not so
- State laws vary on how long they must be kept (between 5-7 years)
- Minors must be kept 5-7 years after their 21st birthday
- Never give an original
- Copies only with an authorized signature
- Note the date, time, what films you dispensed, and to whom (usually have a form)
### Patient History

**Discussion Questions**

What if the patient requests to see his chart. How would you handle that?

Which of the following accreditation agencies specify guidelines for documentation?
1. The Joint Commission (JCH)
2. Centers for Disease Control
3. The American Society of Radiologic Technologists
4. American Bar Association

Why is it essential that the radiographer be objective & accountable in record keeping?

### References