



Documentation Excellence: The Trifecta

■ Brad Laymon, PA

In the dynamic environment of urgent care (UC) medicine, precise, and thorough documentation serves as a cornerstone for both clinical and operational success. Beyond merely fulfilling regulatory requirements, documentation excellence has 3 critical functions, which I refer to as the “trifecta:” 1. Improved patient outcomes through clear communication of care; 2. Mitigation of malpractice risk through clear and defensible explanation of medical decision making (MDM); and 3. Accurate description of complexity to allow for appropriate medical coding. By addressing these 3 distinct functions of the medical record, UC clinicians can ensure optimal care for patients and that their care is well justified and reimbursed fairly.

1. Improved Patient Outcomes

Understanding a patient’s past medical history (PMH) and prior episodes of care is obviously critical for our MDM. Therefore, it cannot be overstated how important comprehensive and clear documentation is for ensuring the delivery of high-quality patient care. As UC clinicians, we treat patients with acute, complex, and time-sensitive needs every shift. Creating an accurate record of our care is crucial for ensuring that subsequent clinicians who see the patient for follow-up understand our MDM and what we have done for the patient. Our documentation provides the foundation for this communication among our fellow healthcare professionals.¹ In other words, our chart should tell a coherent and concise story. Our diagnosis and plan should be supported by the history and exam.

Key components of documentation for optimal patients’ outcomes include:



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- **Thorough history and exam findings:** Include all relevant history, detailed physical examination findings pertinent to the chief complaint, and important negatives/absent features of their presentation to create a complete clinical picture.
- **Diagnostic justification:** Provide the clinical rationale for the diagnostic tests ordered or omitted and ensure they align with the patient’s clinical presentation.
- **Clear treatment plans:** Outline specific, actionable treatment plans and discuss alternatives if applicable. For example, over the counter (OTC) analgesia PRN (as needed) is vague. It’s more helpful to document acetaminophen 1,000mg every 8 hours PRN, for instance.
- **Clear follow-up plan and patient understanding:** Clearly document follow-up recommendations and verify the patient’s understanding of instructions and agreement with the treatment plan. A follow-up plan should be time specific (eg, follow-up in 5-7 days) and action specific (eg, here or with your primary care provider [PCP]).

Appropriate documentation supports improved outcomes in the following ways:¹

- **Prevents miscommunication:** Accurate and detailed records reduce the likelihood of misunderstanding and subsequent medical errors during transitions in care. We’ve all encountered scenarios where we are seeing a patient who “bounces back” and can understand the implications of having to guess what happened at the initial visit because it was not clearly charted.
- **Facilitates early interventions:** Documentation of risk factors and clinical findings can prompt timely interventions and reduce complications. In UC, we often see patients who have gaps in primary care and standard preventative screenings. By reviewing chronic conditions, we can serve as the last line of defense against overlooked chronic care deficiencies.

Table 1. Example of Excellence in Documentation

Substandard Documentation

“Patient presents with chest pain. Given aspirin. ECG is normal. He is alert and oriented X 3 and vital signs are stable. Referred to ED.”

Exemplary Documentation

“43-year-old male presents with retrosternal chest pain for 2 hours, radiating to the left arm, associated with diaphoresis. Vital signs: BP 140/85, HR 95, SpO2 98% on room air. Denies nausea, vomiting, or prior similar episodes. ECG performed shows normal sinus rhythm with no acute ST changes. Cardiac exam unremarkable, lungs clear to auscultation. Given 325 mg aspirin, IV access established, and referred to the emergency department for further evaluation to rule out acute coronary syndrome. Patient counseled on the importance of immediate evaluation; he verbalized understanding and agreed to proceed.”

- **Enhances chronic disease management:** For patients with recurrent conditions, documentation of past treatments and outcomes is useful for creating the most effective plan. If you review charts from psychiatrists, you’ll often find good examples of this practice. For example, in patients with depression, a list of previously attempted treatments with a short discussion of response and/or adverse reactions can be very helpful for ensuring that any subsequent medication trial is not duplicative or likely to cause harm.

Table 1 gives 2 examples of documentation. Notice how the enhanced clarity of the second example supports continuity of care through clear charting of critical information.

Tools to enhance documentation for outcomes include:

- **Clinical decision rules (CDR):** Tools such as the HEART score and PERC rule have been proven to assist in risk stratification of patients with potentially dangerous chief complaints such as chest pain and dyspnea. Integrating CDR tools and reminders within the electronic medical record (EMR) ensures that dangerous diagnoses are considered, and the clinical assessment of the of risk is justified.^{2,3}
- **Standardized protocols:** Use condition-specific templates to ensure no essential details in the history and physical exam are omitted. This “checklist” function can mitigate the risk of diagnostic error and improve patient safety.⁴ At the same time, it is important to allow the template to be modifiable to be specific to each patient encounter. Even 1 or 2 sentences of free text in the history and MDM can

Table 2. Example of Diabetes Documentation

Substandard Documentation

“Diabetic foot pain. Check blood sugar daily. Advised rest and over-the-counter analgesics. Follow up with primary care provider or go to the ED if symptoms worsen.”

Exemplary Documentation

“62-year-old male with a history of type 2 diabetes presents with left foot pain for 3 days. Denies trauma, fever, or chills. Examination reveals erythema, swelling, and a 2 cm ulcer on the plantar surface with purulent drainage. Pedal pulses palpable bilaterally. Sensory exam shows diminished sensation in the left foot. Foot XR does not show evidence of osteomyelitis. Diagnosis: diabetic foot infection. Initiated empiric oral antibiotic therapy with amoxicillin-clavulanate. Advised strict offloading and follow-up here or with PCP in 48 hours for reassessment. Patient educated on infection risks and signs of worsening. He understands to go to the ED if symptoms do not improve over the next 24 hours. He verbalized understanding and agreed with the treatment plan.”

be sufficient for decreasing an impersonal impression of the encounter to subsequent readers.

- **Clinician education:** Given the central role of the EMR in modern UC practice, it is important that clinicians receive regular education on documentation updates and best practices.

Table 2 demonstrates how excellent documentation should capture the complexity of each case. The expanded documentation ensuring all relevant aspects of care are addressed and communicated, which directly supports better outcomes for the patient who presented with foot pain. While the exemplary documentation is longer, it is important to note that most EMRs will allow for macros (eg, “dot phrases”) to be used for standard practices used with each patient. The use of these shortcuts can improve efficiency by including phrases such as “patient verbalized understanding of plan and emergency department (ED) precautions and all questions were answered prior to discharge.”

2. Mitigation of Malpractice Risk

In the unfortunate event where a clinician is named in a lawsuit, their documentation of care is the primary piece of evidence; the quality of documentation is what determines if the chart will better serve the prosecution or defense of their care. Incomplete or vague documentation remains a significant factor in malpractice claims. Conversely, proper documentation serves as a clinician’s strongest defense, illustrating adherence to the standard of care and demonstrating thorough clinical reasoning.⁵ Legal experts consistently emphasize that “if it’s not

Table 3. Example of Documentation for Defensibility of Care**Substandard Documentation**

“Patient seen for leg swelling. No history of DVT. Homan’s sign is negative. Recommended use of compression stockings. Follow up as needed.”

Exemplary Documentation

“67-year-old female presents with unilateral left lower extremity swelling for 3 days. No history of trauma. Denies dyspnea, chest pain, or fever. Exam reveals pitting edema in the left calf, measuring 3 cm larger than the right. No erythema or warmth. Venous Doppler ultrasound ordered for later today to rule out DVT. Recommended compression stockings pending negative imaging results. Educated patient on potential causes, including DVT, and emphasized the importance of immediate follow-up. Documented understanding of risks and early warning signs requiring emergency care. She understands and agrees with the treatment plan.”

documented, it didn’t happen.”

Key elements of documentation to reduce medicolegal risks include:

- **Inclusion of a differential diagnoses:** Document the differential diagnoses considered, along with supporting or ruling-out criteria for dangerous diagnoses. There are debates about how exhaustive this list should be, but including at least a partial differential in the MDM is generally advisable as it demonstrates the clinician’s conscientiousness and diligence.
- **Medical decision making:** The MDM portion of the note is the primary location for justification of your care. In cases of adverse outcomes, expect that it will be scrutinized. For this reason, it is important to provide explicit reasoning for the diagnostic and treatment choices you make, including why certain options were excluded. Avoid using vague statements such as “monitor symptoms” or “follow up as needed,” which do not imply that clear, actionable counseling was given to the patient.
- **Informed consent and patient education:** Informed consent is a process, not a document. The critical aspects of informed consent are a discussion with a patient who has decision making capacity and documentation of their understanding about risks, benefits, and alternatives for treatments or procedures. Note patient questions and their level of understanding.⁶ For situations where there are various reasonable options, document a brief description of the shared decision-making process that went into the final treatment decision.⁷ When it is clear

that patients were involved in the decision process and opted for the treatment course selected, it is much more difficult to assign blame for an adverse outcome to the clinician.

- **Follow-up instructions:** Include time and action specific follow-up instructions and return precautions. (eg, “Contact your PCP if fever exceeds 101°F or the pain worsens within 48 hours. If you cannot be seen by your PCP that day, return to the UC immediately for reassessment”). While rarely necessary, it is prudent to include instructions on when to seek care in the ED and when the patient should call for emergency services (ie, 911).
- **Course of care while in the UC:** Document any changes in the patient’s condition and the resulting adjustments in care plans. Documentation should also include repeat vital signs and physical exam findings after treatments such as injections, nebulizer treatments, or any other in-clinic treatments. Regardless of treatments, significantly abnormal vital signs should be repeated to ensure they are normalizing or stable with a reasonable explanation. Certain abnormal vital signs, particularly tachycardia, have been shown to be associated with increased risk of adverse outcomes after discharge.^{8,9} Repeating vital signs to ensure they are not worsening and commenting on plausible causes of abnormalities which do not suggest serious pathology (eg, pain, anxiety) is an important tool for risk mitigation in such cases.

Table 3 demonstrates 2 versions of clinical reasoning. Notice how the thoroughness in the exemplary version differs from commonly seen, substandard documentation and the key aspects that differ to strengthen the defensibility of care.

How documentation mitigates legal risk:

- **Demonstrates adherence to standards of care:** Detailed records validate that clinical decisions were made based on established guidelines and common medical practices in similar situations.
- **Minimizes ambiguity:** Comprehensive documentation eliminates gaps that could be misinterpreted during legal review.
- **Supports continuity of care:** Accurate records reduce errors in ongoing management, thereby limiting the risk of adverse events due to confusion in interpretation of the EMR by subsequent clinicians.

Consider how the real-world case in **Table 4** demonstrates clear clinical reasoning and proactive patient communication.

Table 4. Example of Abdominal Pain Documentation

Substandard Documentation

“Abdominal pain. Vital signs stable and he is in no distress. Referred to ED.”

Exemplary Documentation

“35-year-old male presents with periumbilical abdominal pain for 24 hours, migrating to the right lower quadrant. Exam reveals tenderness at McBurney’s point with guarding and rebound. Discussed my concern for the possibility of appendicitis, which may necessitate emergency surgery. Patient understands concern. Referred immediately to the ED for further evaluation and management. He was offered EMS transport but declined. His wife will drive him directly to the ED.”

Imagine now that the patient above was diagnosed with ruptured appendicitis when he ultimately presented to the ED 2 days later. In the first example, the documentation does not support that the clinician expressed concerns over the possibility of appendicitis or needing emergent intervention. Compare this to the second example. The chart clearly documents communication of the concern and the implications of a diagnosis of appendicitis. For higher risk cases (ie, where there’s suspicion for possible serious diagnoses), it is important to take an extra moment to ensure that your care, concern, and communication are clearly charted. These are the cases where there’s the highest risk for an adverse outcome, and it is critical to ensure that recognition of this possibility is apparent through your documentation.

3. Accurate Medical Coding

While the topic may seem mundane, clinicians have an ethical mandate that patients are billed appropriately for the care they receive. Accurate and thorough documentation is the cornerstone of proper medical coding, which directly affects reimbursement, compliance, and financial sustainability. Poor documentation can lead to both claim denials and overcoding, which can have significant financial and administrative repercussions. Coders and coding algorithms rely on the details of the medical record to assign the appropriate codes that reflect the complexity and specificity of the services provided.

Key considerations for accurate coding for billing purposes include:¹⁰

- **Specific terminology:** Use precise clinical language to support the highest level of coding specificity. For example, if a patient has an asthma exacerbation, documenting whether they have intermittent or persistent asthma may affect the complexity of care.

Table 5. Example of Appropriate Documentation for Accurate Assignment of CPT and ICD-10 Codes

Substandard Documentation

“Laceration repair. 2 cm laceration closed with 4 -0 nylon sutures. Follow up in 7-10 days.”

Exemplary Documentation

“2 cm linear laceration on the dorsal surface of the left hand, extending into the dermis. Wound irrigated with 500 mL normal saline. Local anesthesia achieved with 1% lidocaine without epinephrine. Layered closure performed with four 4-0 nylon sutures. Patient advised on wound care, signs of infection, and follow-up in 7 days for suture removal.”

- **Diagnosis and procedure linkage:** Ensure all diagnoses are explicitly associated to the relevant procedures and treatments administered.
- **Clear procedure notes:** For lacerations and abscesses, ensure that the location, size, complexity of repair/drainage, technique, and materials used are documented to accurately reflect the procedure performed.

This level of specificity in **Table 5** ensures the correct Current Procedural Terminology (CPT) code and International Classification of Diseases (ICD-10) diagnosis are assigned. Accurate CPT codes are the basis for appropriate reimbursement and compliance.¹¹

Benefits of accurate medical coding include:

- **Optimized reimbursement:** Detailed documentation ensures claims are not denied and reimbursement is not delayed due to lack of clarity or supporting information.
- **Audit protection:** Complete and specific records reduce the risk of coding errors which may result in penalty if identified during payer audits.
- **Compliance with regulations:** Accurate coding prevents unintentional violations of payer policies, safeguarding against penalties.

Common documentation pitfalls relevant to billing and coding to avoid include:

- Vague descriptions of chief complaints like “follow-up visit” without context or clinical findings.
- Failing to document patient non-adherence or patient declination of recommended tests or treatments.

The examples of documentation in **Table 6** demonstrate variable precision in language, which can have significant effects on appropriateness of coding for both the procedure and the associated diagnosis.

High-yield tips and strategies for achieving the “trifecta” include:

- **Use of standardized templates:** Utilize chief com-

Table 6. Example of Documentation for Complex Abscess with Incision and Drainage**Substandard Documentation**

“Incision and drainage of abscess.”

Exemplary Documentation

“3 cm fluctuant abscess on the left axilla, erythematous and tender to palpation. Area prepped with chlorhexidine. Local anesthesia achieved with 5mL of 1% lidocaine with epinephrine. Incision made with #11 blade, and 10 mL of purulent material expressed. Cavity irrigated with normal saline and dressing applied. Patient advised on dressing changes, signs of worsening infection, and follow-up here in 48 hours for wound check. Patient verbalized understanding.”

plaint specific templates designed to prompt comprehensive documentation. Ensure simultaneously that the templates allow for flexibility for various types of presentations. The use of such templates can reduce omissions and oversights and improve consistency across clinicians.

- **Engage in ongoing education:** Periodic training sessions to review updates on documentation best practices, coding guidelines, and medicolegal considerations can serve as important reminders for standards of care and ensure awareness of relevant updates (eg, revision in evaluation and management coding).
- **Solicit audits and feedback:** Request periodic audits from peers, supervisors, and coding professionals to assess the quality of your documentation for all aspects of the trifecta. This offers the opportunity for actionable, specific, and constructive feedback.
- **Embrace technological integration:** Leverage functions within the EMR. For example, practice using embedded CDRs and macros to enhance documentation quality and efficiency. If available and approved for use in your UC center, try using documentation and/or artificial intelligence scribing applications.
- **Support a collaborative environment:** Encourage open communication between clinicians, staff, and coders when ambiguities are identified

Conclusion

For better or worse, the quality of our care is largely judged based on the quality of our documentation. Excellence in medical documentation, therefore, is far more than an administrative responsibility, but rather

represents a fundamental skill with implications for every aspect of UC practice. By striving to achieve the trifecta—improved patient outcomes, mitigation of malpractice risk, and accurate medical coding—clinicians can protect their patients, themselves, and their UC center. ■

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