College of Pharmacy
Center for the Advancement of Pharmacy Practice

CAPP RESOURCE | ONE-PAGER

Documentation Pearls

A guide on what to include in notes to support medical necessity and coding.

Why Documentation Matters

Documentation is the foundation of patient care, ensuring effective communication between healthcare providers through a thorough detailing of clinical encounters. Accurate documentation is also critical to successful billing for services, as documentation justifies the codes that are submitted with each claim.

THE NINE ELEMENTS CMS EXPECTS IN EVERY ENCOUNTER

CMS recommends that every patient care note contain the following nine elements. Use them as a mental checklist before signing off on any encounter.

Date of Service*	**Reason for Encounter**	**Relevant History**
Exam Findings	**Results**	**Clinical Assessment**
Plan of Treatment	**Plan for Follow-Up**	**Date & Provider Signature^**

*Date of service is the date of the patient encounter; ^Signature Date is when the note is finalized.

DOCUMENTATION FORMATTING

If you are not using an electronic health record with a structured documentation format, a “SOAP note” format is universally understood by other providers and reviewers. This freestyle format allows for a logical grouping of information and quick retrieval of relevant details later.

	Information Contained in the Section
S — Subjective	What the patient (or caregiver) tells you. Chief complaint, history of present illness, past medical/family/social history, current medications, adherence concerns.
O — Objective	What you measure or observe. Vital signs, lab values, point-of-care test results, physical exam findings.
A — Assessment	Your clinical interpretation. List problems addressed in priority order; document the reasoning behind your conclusions.
P — Plan	Decisions and next steps. Therapy initiated/changed, education provided, referrals, follow-up timing, additional tests ordered. Include rationale.

DOCUMENTATION BEST PRACTICES

- **Write while it’s fresh.** Document at the time of the encounter or immediately afterward to be as detailed and accurate as possible.
- **Be specific.** Detailed notes provide justification for services performed and billed for. E.g., Instead of saying “educated patient on medication,” say “educated patient on medication mechanism of action, side effects, and how to appropriately take.” Instead of saying “spent significant time with patient” give a specific number.
- **Use templates as a starting point for notes.** Ensure that each note is customized to the actual encounter.

COMMON PITFALLS

- **Listing comorbidities** the patient has that were not relevant to/actively addressed during the visit.
- **Forgetting to sign and date** notes can lead to it being treated as if the service did not occur.
- **Documenting only what supports coding** rather than everything that happened. Let the code follow from the documentation.