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Health Information Compliance Alert

Documentation: Code Charts Properly Every Time by Nailing Down Acronyms

Would you be able to count E/M bullets properly if the physician wrote 'WBC WNL'?

Sometimes physicians actually do speak in "code" -- by using specialized acronyms that they may have learned in medical school -- or sometimes, that they've made up on their own. But if you can't differentiate between the terms they write down in their charts, your coding may suffer.

Here's why: When the physician documents a chart, he doesn't always have time to spell out phrases such as "past history" (PH) and "present illness" (PI), but knowing which is which can make a tremendous difference in the accuracy of your charts. If you code a chart assuming that the patient currently suffers from every condition listed as "PH," you'll be coding the wrong diagnoses for the current illness.

Because of the extended disease and procedure names in the healthcare world, physicians use a system of communication using acronyms and abbreviations to facilitate more efficient communication among other medical professionals.

What is it? An acronym is a word formed from the initial letter (or letters) of words in a phrase or multi-word description. Unfortunately, in addition to being more efficient, the onslaught of acronyms has increased the possibility of error because of misunderstandings of the acronym or abbreviation. For instance, you may see a radiology report that refers to "FS," which could indicate a "fracture, simple" or may just mean that the film was shot while the patient's forearm was supinated.

Best bet: Get to know the most frequent acronyms for your practice. You can memorize them, keep a cheat sheet on hand, refer to a medical dictionary, or use another resource. And when all else fails, you can ask the physician who documented the acronym for a definition.

Example 1: The physician documents the following note:

"35 y.o. new pt. requires treatment for UTI determined by abn. C&S." In this case, a 35-year-old new patient required treatment for a urinary tract infection (UTI) that the urologist diagnosed via an abnormal (abn.) culture and sensitivity test (C&S).

Example 2: Suppose the doctor documents that the WBC is WNL. In this example, the patient's white blood count is within normal limits.

Example 3: You see an orthopedist's chart indicating that an "85 y.o. est. pt. requires THR for AVN." Here, the 85-year-old established patient required a total hip replacement (THR) for avascular necrosis (AVN).

Example 4: An ophthalmologist documents that a "35 y.o. new pt. requires examination. CC is BS. Pt. Previous dx: AODM." Translated into real-world terminology, this physician saw a 35-year-old new patient requiring examination and evaluation due to a chief complaint of a blind spot in her vision. The patient has a previous diagnosis of adult onset diabetes mellitus.

Know internal acronyms: In some cases, physicians will create their own phrases that they and their partners use, but that you may not have heard from your previous employers. Keep a list of those internal acronyms so that you and your fellow staff members can keep track of them.

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