

## Three Little Phrases

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I have written many times now about the importance of good, clear, complete [documentation](#). No doubt it is a pain – it takes up time and energy we would all rather put toward patient care. But there is really no choice anymore; the standard of care and the new health care laws require a higher level of documentation. Electronic medical record software will soon not even be an option, but a requirement for being in practice.

Electronic records still require you to sit down and enter most of the new-patient data. After that visit, you may be able to "roll-over" much of the information day to day. There may not always be a great change in the patient status on every visit, but each day note should have some relevant information about the patient's condition at that time. I have found a few key phrases helpful in reinforcing my daily treatment record.

### PVU: Patient Verbalized Understanding

If you have been in practice for any amount of time, you know that patients are not always compliant with your home instructions. They may need to rest at home with ice on their back, stay off a sprained ankle on crutches, or drink more water – but that doesn't mean they are going to follow through. I have had patients feel better with care and decide to go home and do more yardwork, only to come back the next day with more pain.

I recall one man even telling me that he was allergic to water and could only drink a beer when he got home from work every day. Patients don't always follow your instruction, but at what point is that your fault? That depends on your notes on the day you gave them the instructions.

If I tell a patient to rest at home with ice, drink water, etc., those instructions must be recorded in the daily treatment note with the phrase "patient verbalized understanding" or simply "PVU." With that note, I have not only recorded what I told them to do, but also that they told me they understood and agreed. After that, if they don't follow through, I can go back to my notes and say, "See, we discussed this."

### PPO: Per Physician Orders / Per Phone Orders

As chiropractic becomes more mainstream, many docs find that they are able to co-manage care with other providers. This is fantastic. Being able to integrate our care does not in any way dilute the value of chiropractic. I have several orthopedic surgeons who will send me low-back disc cases because they would prefer not to do surgery; they also send me patients who have already had surgery. The fact that this patient was referred from an orthopedist does not in any way diminish the value of chiropractic care. But here again, the evolving rules of health care documentation come into play.

I have the ability to call these other providers on the phone to discuss the case and the care plan. There are times when the other doc may give me specific direction or insight on a patient. If I have a clear directive from the other doctor, I should note that in my file on that date. If I am following or modifying a care plan at the direction of another doctor, I will conclude that entry with "PPO,"

which is short for "per physician orders" or "per phone orders." Obviously you need to note the other provider you spoke with and the particulars of the conversation.

WI: Without Incident

The last phrase helps to define the patient's status after your care on a given date. After you have rendered care, how does the patient feel? Are they better? Worse? Stiff? Sore? Achy? You should have a notation about how the patient feels after your treatment.

They may feel fantastic, or they might still be sore. A patient who comes in with acute spasm is probably going to need a few hours of rest and ice - we are not going to magically dissolve all that congestion. The body has an amazing ability to heal, but the normal process of healing does take some time.

In any case, make sure you comment on how the patient feels after your care on each date. Often the phrase "without incident" or "WI" can be used. I have also seen the phrase "responded as anticipated." Some of the [transcription programs](#) already have this verbiage in the system. This phrase basically records that after your treatment, the patient did not have a negative reaction to your care.

Finally, it should be obvious that these quick notations should be incorporated into the notes on the date of service - not after the fact. Going back and modifying the patient record days or weeks after the care was provided is not appropriate, and only serves to suggest your notes were not adequate. You must provide clear, accurate, information contemporaneous to the visit. Like it or not, documentation paperwork is part of professional health care. I hope these quick phrases make your paperwork a little easier.

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