THE INJURY PLAYBOOK LIBRARY

Medical Provider PI Documentation Checklist

A record-completeness reference for treating providers and clinical staff documenting a personal injury case.

Personal injury cases place additional documentation demands on the medical record beyond routine clinical care. Adjusters, defense counsel, and courts will scrutinize the chart for completeness, internal consistency, and clear support for causation and prognosis. Use this checklist alongside your practice's clinical documentation standards to help ensure the chart can stand on its own if the case proceeds to litigation.

1. Initial Evaluation and History

Establish a clear clinical baseline at the first visit.

- [ ] Mechanism of injury documented in the patient's own words, in detail
- [ ] Date, time, and location of the incident recorded and consistent with intake forms
- [ ] Onset and location of symptoms documented, including any delayed-onset symptoms
- [ ] Prior medical history reviewed and documented, including pre-existing conditions
- [ ] Prior injuries to the same body region specifically addressed and distinguished
- [ ] Review of systems completed and documented, not left blank or marked 'unremarkable' by default
- [ ] Baseline functional status and limitations documented (work, daily activities, hobbies)

2. Clinical Findings and Diagnosis

Objective findings support the diagnosis; the diagnosis supports the case.

- [ ] Objective examination findings documented (range of motion, strength, neurological signs)
- [ ] Diagnosis clearly stated using specific, correctly coded terminology (ICD-10)
- [ ] Diagnostic imaging ordered where clinically indicated, with findings documented in the chart
- [ ] Imaging and clinical findings cross-referenced and any discrepancies addressed
- [ ] Differential diagnoses considered and ruled out where relevant, with reasoning noted
- [ ] Severity and functional impact of each diagnosis clearly characterized

3. Causation Documentation

This section is often the most heavily scrutinized part of the record.

- [ ] Explicit causation statement included: whether findings are consistent with the reported mechanism of injury
- [ ] Statement addresses degree of medical probability (e.g., "more likely than not") where applicable
- [ ] Pre-existing conditions addressed directly: aggravation vs. new injury clearly distinguished
- [ ] Any gaps in treatment explained or addressed in the record, not left unexplained
- [ ] Alternative causes considered and, where ruled out, the reasoning documented
- [ ] Causation opinion is consistent across all visit notes and any narrative reports

4. Treatment and Progress Documentation

A consistent, well-documented treatment course strengthens the record.

- [ ] Treatment plan documented at each phase of care, with rationale for changes
- [ ] Patient progress (improvement, plateau, or regression) documented at each visit
- [ ] Response to each treatment modality noted (medication, therapy, injections, surgery)
- [ ] Missed appointments, non-compliance, or delays documented with any stated reasons
- [ ] Referrals to specialists documented with reason for referral and outcome
- [ ] Home exercise programs, restrictions, or work limitations documented and updated

5. Prognosis and Maximum Medical Improvement (MMI)

Clearly document the expected clinical course and endpoint of treatment.

- [ ] Prognosis clearly stated and updated as treatment progresses
- [ ] Maximum Medical Improvement (MMI) date documented when reached, with supporting rationale
- [ ] Permanent impairment addressed and rated using an accepted method, if applicable
- [ ] Expected long-term limitations or restrictions clearly documented
- [ ] Likelihood of symptom recurrence or degenerative progression addressed, where relevant

6. Future Medical Care and Cost Considerations

Support any anticipated future treatment with clear clinical reasoning.

- [ ] Anticipated future treatment specifically identified (surgery, injections, therapy, monitoring)
- [ ] Frequency and duration of anticipated future care documented (e.g., visits per year)
- [ ] Anticipated durable medical equipment or home modifications documented, if applicable
- [ ] Basis for future care recommendations tied to the diagnosis and clinical course
- [ ] Life care planning or future cost projection requests coordinated with the appropriate specialist, if outside the treating provider's scope

7. Billing, Coding, and Record Integrity

Confirm the billing record matches the clinical narrative before release.

- [ ] CPT and ICD-10 codes match the documented services and diagnoses for each visit
- [ ] Itemized billing statements available and reconciled against the chart
- [ ] Chart entries signed, dated, and authenticated per practice policy
- [ ] Late entries or amendments clearly marked as such, with date of entry
- [ ] Record reviewed for internal consistency across providers, if multiple clinicians are involved

8. Narrative Reports and Records Requests

Prepare for medical-legal use before records leave the office.

- [ ] Narrative report addresses history, diagnosis, causation, treatment, prognosis, and future care
- [ ] Narrative report is consistent with the underlying chart notes
- [ ] Signed HIPAA-compliant authorization on file before releasing any records
- [ ] Complete record produced in response to requests, including all providers and ancillary notes
- [ ] Copy of any records or narrative report sent retained in the patient's file

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This checklist is a general clinical documentation reference for treating providers and clinical staff. It does not constitute legal advice and does not replace your practice's clinical documentation standards, state licensing board requirements, or HIPAA obligations. A companion checklist addressing law firm and attorney documentation practices is available separately.

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