Special Article

SOAP to SNOCAMP: Improving the Medical Record Format

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Not since the development of the SOAP note in the problem-oriented medical record has there been a significant need to alter the format of medical record documentation. With the intrusion of third-party audits, malpractice attorney subpoenas, medical guidelines, and reimbursement code criteria into the practice of medicine, there is a need to expand the traditional SOAP note. This article proposes a new acronym, "SNOCAMP," for medical record documentation. SNOCAMP retains the SOAP format, which includes subjective, objective, assessment, and plan of treatment, with the addition of nature of the presenting complaint, counseling, and medical decision-making. It is hoped that this new, more explicit format will prove successful in meeting the divergent needs of practicing physicians, the patients they serve, and the inquiring minds that look over their shoulders.

Key words. Medical records, problem-oriented; documentation. (*J Fam Pract 1995; 41:393-398*)

It is understandable that so many experienced family physicians deplore the current fate of "their" medical records. Long considered a journal of personal notes and of cherished doctor-patient relationships, the patient record has now become accessible to third-party payers, insurance companies, governmental "intruders," and attorneys. In these times of managed care, frequent patient transfers, group practices, and litigation, documentation has become more and more important: it has now reached the point that if something is not documented, it is de facto considered not to have happened.

As a defense against new Medicare documentation guidelines and the increased risk of physician practice audits, with their inherent cost and hassles, wise physicians are considering ways to improve their documentation[1] without sacrificing ease of use, efficiency, and cost-effectiveness. It is for these physicians that the SNOCAMP format of medical record documentation was developed in early 1992 by one of the authors (W.L.L.). This format was first illustrated in a guidebook on documentation published in 1993.[2] The purpose of this article is to describe and more fully illustrate the utility and value of this new format.

The SNOCAMP format allows the identification of the elements of an evaluation and management (E&M) service code to be specifically designated by the physician. In this new method of medical record documentation, the nature of the patient's presenting problem, medical decision-making, and counseling are all specified by the physician. These elements are then combined with the classic components of the SOAP format (subjective, objective, assessment, and plan of treatment).[3]

As in the SOAP format of medical documentation, subjective is the first component in the SNOCAMP format. In this portion of the medical documentation, the patient's chief complaint, all pertinent information regarding the history of present illness, system review and past, social and family history are recorded.

Designation of the nature of the presenting problem (NPP) is the second component of SNOCAMP. This aspect of SNOCAMP describes the complexity or severity of the patient's chief complaint, which can be a disease, condition, illness, injury, symptom, sign, finding, or other reason for the encounter. The physician's opinion of the NPP—not an auditor's—is a vital component of documentation, as it plays a critical role in determining the

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Table 1. Defining and Documenting the Nature of the Presenting Problem: the "N" in SNOCAMP

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E&M codes recognize five types of presenting problems that are defined as follows:

Minimal: A problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

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appropriate level of an E&M service code. This component was first considered a documentable component of an E&M service when it was published in the CPT book in 1992.[4] The physician's subjective perception of the NPP influences the extent of history obtained, the extent of examination performed, and the complexity of medical decision-making. The NPP component is easily described in terms of one of five possible levels: minimal, self-limited or minor, low severity, moderate severity, and high severity (Table 1). When the nature of the presenting problem falls between two descriptor levels, eg, low to moderate, it can be stated as such or can be described as the more complex of the two. The word "potential" can be added to demonstate to outside observers the physician's concern regarding the potential severity of the presenting complaint (eg, anterior heavy chest pain could easily be described as "potential high severity," even if subsequent workup revealed that the patient only had costochondritis).

The objective or examination component, which is the third component of the SNOCAMP format of medical documentation, contains the important positive and negative findings of the physical and mental examination. Each organ system should be itemized in the record, and the pertinent findings of each system should be detailed. Abnormal findings should be detailed; however, findings that are within normal limits (WNL) can be stated as such, eg, "GI—WNL." It may be appropriate for a physician to keep a separate detailed record of what this normal examination entails (eg, "GI WNL = abdomen soft, flat, and nontender; no organomegaly guarding, rebound, scars, costovertebral angle or anterior costal margin tenderness; normoactive bowel sounds.") This type of description can be useful if the physician is ever questioned by an auditor or attorney as to exactly what is meant by WNL. A recent article on documenting the examination more fully explains this component.[5]

Counseling and coordination of care comprises the fourth section of the SNOCAMP format. This component of medical record documentation is critical to family physicans. Most family physicians are trained and eager to provide counseling to their patients; however, most of us are deficient in documenting the excellent patient education we provide. The importance of this component is that when counseling or coordination of care consumes more than 50% of the total face-to-face visit time, this element is the key or controlling factor for selecting the appropriate level of E&M code. Using standard SOAP documentation, it is difficult to determine that counseling or coordination of care is the key factor in the visit. We believe that most auditors, attorneys, and patients grossly underestimate the quantity and the quality of this service. Therefore, specifically designating this information, as well as recording the time involved in providing this service, can be extremely valuable for family physicians, as it will help substantiate the elements that should be taken into consideration when a level of E&M service code is selected.

Consider, for example, a level 2 established patient E&M service (CPT code 99212), which is considered by the CPT authors to involve an average of 10 minutes for the follow-up of bilateral acute otitis media with effusion. Physicians who spend another 20 minutes counseling the mother about the cost, risk, and benefit of prophylactic

Table 2. Defining and Documenting Medical Decision-making: the "M" in SNOCAMP

No. of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Complexity of Decision-making
minimal	minimal or none	minimal	straightforward
limited	limited	low	low
multiple	moderate	moderate	moderate
extensive	extensive	high	high

antibiotics vs ventilation tubes could consider coding the visit as a level 4 E&M service (CPT code 99214), since this code is considered to take an average of 25 minutes. Under these new coding guidelines, physicians can feel more at ease when a patient says, "Oh, by the way . . . ," as they can now appropriately code for and be reimbursed for the medically necessary counseling they provide.

When documented, the counseling component also can provide the physician with excellent malpractice protection. For example, the simple dictation of "PAR [procedure, alternatives, and risks] discussed with the patient and husband." Equally short, but compellingly complete dictation could include "Diagnostic results and impressions, risk vs benefit of several management options, medication side effects, and follow-up were discussed." Other examples of complete dictation include: "20 minutes spent counseling patient about smoking cessation options and stress management techniques," or "Discussed potential corticosteroid risks and side effects. Pt chooses to proceed with injection," and "20 minutes spent encouraging pt to proceed with biopsy of new breast lump. PAR discussed. Pt chooses to repeat mammography in 3 mos, understanding that the tumor may be more difficult to treat then," or "15 minutes spent discussing pt grief over recent loss of his mom." It would be very difficult for an outside agent to successfully allege that a given service was not provided when documentation such as this so clearly substantiates that it was.

The assessment component is the fifth section of the SNOCAMP format. This component expresses the physician's determination of the patient's problem in terms of the diagnoses or the differential diagnosis. Documentation in this section can include any potential for complications and morbidity or mortality, unless this has already been documented in the counseling section.

The sixth component of the SNOCAMP format, medical decision-making is specified by the physician and includes the complexity of establishing a diagnosis or selecting a management option. The level of medical decision-making is best assessed by the physician because it is subjective, complex, and requires professional judgment. Determination of the appropriate level of medical decision-making comprises multiple factors, which include the number of potential diagnoses or management options, amount and complexity of data to be reviewed, and risk of complications and morbidity or mortality. The type of medical decision-making must be based on information recorded in the counseling, assessment, and plan components of the medical record. The CPT book outlines four types of medical decision-making: straightforward, low complexity, moderate complexity, and high complexity. These terms are defined in Table 2 and discussed elsewhere in more detail.[6]

The final section of the SNOCAMP format involves the plan of treatment or treatment options the physician will utilize in managing the patient's problem(s). This component also should include the rationale for recommending or changing a previously designated therapy or ordering of diagnostic tests, unless already discussed in the counseling or the assessment sections.

Tables 3 to 5 illustrate three paired office notes, one using the SOAP format, and the same encounter using the SNOCAMP format. There is an obvious difference between the two formats with respect to the information available to outsiders viewing the chart.

It is important for physicians to remember that the selection of an appropriate level of E&M service code depends on the documented components. Utilizing the SNOCAMP format enables a physician to present documentation efficiently and effectively in a style that will

Table 3. Example of Level 2 Established Patient Office Visit (CPT Code 99212)

SOAP Note	SNOCAMP Note
S: Pt. returns for suture removal 10 days after laceration repair in the ER. No complaints.	**S:** Pt. returns for suture removal 10 days after laceration repair in the ER. No complaints.
O: Wound healed well. Sutures removed without difficulty.	**N:** Minor
A: Arm laceration—healed.	**O:** Wound healed well. Sutures removed without difficulty.
P: F/U prn.	**C:** Discussed with patient and her mother expected course of healing, wound protection, and sun protection.
	A: Arm laceration—healed.
	M: Low complexity
	P: F/U prn.

Table 4. Example of Level 3 Established Patient Office Visit (CPT Code 99213)

SOAP Note	SNOCAMP Note
S: Pt. presents with 3-day history of slowly worsening bilateral maxillary facial pain, stuffy nose, postnasal drip, and sore throat. No respiratory or GI symptoms. No fever. No history of allergy or sinus problems.	**S:** Pt. presents with 3-day history of slowly worsening bilateral maxillary facial pain, stuffy nose, postnasal drip and sore throat. No respiratory or GI symptoms. No fever. No history of allergy or sinus problems.
O: Gen: Looks well. HEENT: Maxillary area pain to palpation bilaterally with decreased maxillary transillumination. Yellow-green nasal and postnasal D/C with mild pharyngeal erythema. Neck: WNL. Chest: WNL.	**N:** Low severity
A: Acute URI and bilateral maxillary sinusitis.	**O:** Gen: Looks well. HEENT: Maxillary area pain to palpation bilaterally with decreased maxillary transillumination. Yellow-green nasal and postnasal D/C with mild pharyngeal erythema. Neck: WNL. Chest: WNL.
P: Pseudoephedrine prn. Acetaminophen prn. Cephalexin 250 mg tid × 10 day. Gargle and lozenges prn. OTC nasal decongestant bid × 3 days only. F/U prn.	**C:** Discussed impression and the cost/risk/benefit of therapeutic options. Potential medication side effects discussed.
	A: Acute URI and bilateral maxillary sinusitis.
	M: Low complexity.
	P: Pseudoephedrine prn. Acetaminophen prn. Cephalexin 250 mg tid × 10 day. Gargle and lozenges prn. OTC nasal decongestant bid × 3 days only. F/U prn.

Table 5. Example of Level 5 Established Patient Office Visit (CPT Code 99215)

SOAP Note	SNOCAMP Note
S: Pt. presents with CC of fatigue. He has had 3 mos. of slowly increasing fatigue, moodiness, and the "blues," with slowly decreasing energy, motivation, concentration, tolerance with coworkers, and libido. Sleep disturbances include EMA and insomnia. Overall he feels "depressed." His primary stressors include separation from his wife for 3 mos. and job stress. He admits suicidal ideation, but would never act on this "because of the kids." Denies infection, fever, chills, flushing, diaphoresis, or resp/GI/GU/skin c/o. Complete ROS, and PMH, SH, FH reviewed are unchanged from annual exam of 6 mos. ago. Of significance, his mom and dad suffer from depression and a brother is on antidepressant medication.	S: Pt. presents with CC of fatigue. He has had 3 mos. of slowly increasing fatigue, moodiness, and the "blues," with slowly decreasing energy, motivation, concentration, tolerance with coworkers, and libido. Sleep disturbances include EMA and insomnia. Overall he feels "depressed." His primary stressors include separation from his wife for 3 mos. and job stress. He admits suicidal ideation, but would never act on this "because of the kids." Denies infection, fever, chills, flushing, diaphoresis, or resp/GI/GU/skin c/o. Complete ROS, and PMH, SH, FH reviewed are unchanged from annual exam of 6 mos. ago. Of significance, his mom and dad suffer from depression and a brother is on antidepressant medication.
O: Gen: Appears slumped and depressed. Tears easily. HEENT: WNL. Neck: WNL. Chest wall: WNL. Lungs: WNL. COR: WNL. Abd: Liver edge is palpable 1 cm below RCM and is smooth. Spleen tip palpated. Neg Murphy punch sign. BS WNL. GU: WNL. Circ. Rectal: WNL. Stool guaiac neg. Ext: FROM with WNL pulses. Skin: WNL. Neuro: WNL. Mental status WNL except flattened affect.	N: Potential high severity O: Gen: Appears slumped and depressed. Tears easily. HEENT: WNL. Neck: WNL. Chest wall: WNL. Lungs: WNL. COR: WNL. Abd: Liver edge is palpable 1 cm below RCM and is smooth. Spleen tip palpated. Neg Murphy punch sign. BS WNL. GU: WNL. Circ. Rectal: WNL. Stool guaiac neg. Ext: FROM with WNL pulses. Skin: WNL. Neuro: WNL. Mental status WNL except flattened affect.
A: Fatigue, posterior cervical adenopathy, and hepatosplenomegaly. R/O depression and/or EBV disease.	C: Discussed differential diagnosis including mood/affective disorder, stress disorder, infection and/or CA. Cost/risk/benefit of diagnostic W/U discussed. Support systems discussed. Pt. will stay with a friend until F/U. A: Fatigue, posterior cervical adenopathy, and hepatosplenomegaly. R/O depression and/or EBV disease. M: High complexity
P: Zung depression and anxiety screening score. Chemistry panel, CBC, EBV profile, sed rate. Rtc. in 2 days to review results.	P: Zung depression and anxiety screening score. Chemistry panel, CBC, EBV profile, sed rate. Rtc. in 2 days to review results.

enhance the selection of an appropriate E&M service code level. The SNOCAMP format also has the potential to increase audit protection and defend against possible litigation by assuring thorough documentation in medical records.

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The SNOCAMP Format Specifications at a Glance

In the SNOCAMP system of medical record documentation, the physician's notes concerning a patient's health and treatment are divided into seven parts:

Subjective: This component summarizes the patient's complaints, generally using the patient's own words or a synopsis (eg, chest pain or sore throat). It should include the nature and duration of the patient's symptoms, the time the patient first noticed the symptoms, the patient's opinion as to the possible causes of the illness or condition, any remedies that the patient may have tried, or other medical treatment previously received for the same illness or condition (chief complaint and present illness).

This portion of the medical documentation also notes responses to questions asked of the patient to help define the problems and determine the health of the patient (review of systems [ROS]). Any past illnesses, including injuries or physical defects (congenital or acquired); medications that the patient is taking; and operations the patient has had (past medical history) should be noted in this section.

Documentation of the patient's marital status, occupation, and daily health habits should be indicated in this section (social history [SH]) as well as the physical condition of various members of the patient's family, any past illnesses or diseases in the family, and the causes of death (family history [FH]). ROS, FH, SH, and PMH (past medical history) information is often included on a family physician's chart in the problem list. Therefore, documentation of these areas can be as easy as saying "PMH, SH, FH, and ROS reviewed and updated."

Nature of the Presenting Problem: This section summarizes the physician's determination of the complexity or severity of the patient's disease, condition, illness, injury, sign/symptom, finding, complaint or the reason for the encounter based on the documentation in the subjective section. The information is specified in terms of the elements—minimal, self-limited or minor, low severity, moderate severity and high severity—recognized in the CPT manual (Table 1).

Objective: This section includes the measurable, pertinent findings of the examination of the affected body area or organ system, eg, vital signs and physical examination findings such as enlarged liver or bilateral edema. Results of diagnostic tests, eg, laboratory tests or x-ray films, are recorded in this portion of the medical documentation.

Counseling and/or **C**oordination of Care: This section details any discussion the physician may have had with a patient and/or family concerning the physician's clinical impression, prognosis, risk and benefits of management options, follow-up instruction, importance of compliance with treatment, risk-factor reduction, and patient and/or family education. When this component is documented, the portion of the total visit spent counseling and/or coordination of care should be indicated.

Assessment: This component of the documentation indicates what the physician thinks the patient's problem is, based on the information obtained in the subjective and objective portion of the examination. It should show the analysis of differential diagnoses, management and treatment options, and potential for complications.

Medical Decision-making: This component designates the appropriate type of medical decision-making (straightforward, low complexity, moderate complexity, or high complexity) based on the documention in the assessment and plan sections and the definitions specified in the CPT manual (Table 2).

Plan: This part of the medical record documentation states the treatment plans, such as a change in medication, prescribed exercise, plans for follow-up or diagnostic tests, or the decision to perform surgery.

In addition to the above information, the medical documentation must be legible and understandable for all providers who care for the patient and for peer review, research, and reimbursement purposes. For example, abbreviations or shorthand used in the medical record documentation should be listed on an identification key accessible to all who read the documentation. All entries should be dated and signed with credentials (eg, MD, DO, etc.). Moreover, medical documentation should be completed as soon as possible after the services provided.