PROFESSIONAL BILLING COMPLIANCE TRAINING PROGRAM

MODULE 1
PRINCIPLES OF MEDICAL RECORD DOCUMENTATION
Principles of Medical Record Documentation

Why Document?

Medical Reasons
- Evaluation, treatment and monitoring
- Communication and continuity of care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care
- Collection of data for research and teaching

Legal Reasons
- In medical malpractice cases, may be final piece of definitive evidence.
Principles of Medical Record Documentation

Documentation of each patient encounter should include:

- Reason for the encounter and relevant history, physical exam findings, and prior diagnostic test results.
- Assessment, clinical impression/diagnosis.
- Medical plan of care.
- Date and legible identity of the performing provider/observer.

Electronic signatures are acceptable – Stamped signatures are not!
Principles of Medical Record Documentation

Other Important Guidelines:
• Past and present diagnoses should be accessible to the treating and/or consulting physician.
• Appropriate health risk factors should be identified.
• Patient’s progress, response to and changes in treatment and revision of diagnosis should be documented.
• Documentation may be dictated and typed, hand-written or computer-generated.
• Use approved abbreviations or standard specialty abbreviations.
• Templates may be utilized as long as they meet the intended use.
• When referencing another note, always identify by name and date.
• Record must be complete and legible.
Principles of Medical Record Documentation

Documentation in the medical record:

- Is the only valid support for billing professional services.
- Must clearly communicate the status of the patient - Tell the story of the patient’s visit.
  - CPT – listing of descriptive terms and identifying codes developed by the AMA for reporting medical services and procedures performed by physicians.
  - ICD-9 CM – diagnosis codes reported on health insurance claim form or billing statement. *

* See Evaluation and Management Services Training Module
Principles of Medical Record Documentation

Confidentiality of medical record:

• Should be fully maintained.
• Consistent with the requirements of medical ethics and applicable state and federal confidentiality laws.
• Password protect your computer and do not share your passwords with others.
• Use only encrypted flash drives or USB keys to protect the integrity of clinical information.
• **True or False:**

  Stamped signatures are not allowed; however, electronic signatures are acceptable.
Documentation Assessment - Answer

• The answer is **True**.

  Electronic signatures are acceptable but stamped signatures are not. Typically, electronic signatures are generated “on-line” by the physician and are password protected.
Documentation Assessment – Question 2

• True or False:

It is acceptable for a provider (MD, NP or PA) to write a postoperative note prior to the completion of the surgical procedure as long as the note supports the medical necessity.
The answer is **False**.

It is never acceptable for the provider to include a postoperative note in the medical record before completion of the procedure. All entries in record must be timely and accurate.
Principles of Medical Record Documentation

Remember!

“If is not documented, it is not done; therefore, it is not billable.”

“If you can’t read it, it is not documented and/or done.”
To ensure that medical record documentation is accurate, the following principles should be followed:

a. Notes should be complete and legible.
b. Documentation should include the date and legible identity of the clinician.
c. A & B.
The answer is (c) A&B.

The medical record should be complete and legible, and all entries to the medical record should be dated and authenticated.
References


• Office of Inspector General (OIG) Compliance Program for Individual and Small Group Physician Practices:  
  www.oig.hhs.gov/authorities/docs/physicians.pdf