

## **MercyCare Insurance Company Medical Record Documentation Standards**

### 1) Demographic Information

- All encounters including telephone contacts are documented in the medical record
- The patient's name/medical record number appears on every document of the chart
- Biographical and personal information, including gender, address, home/work telephone numbers, marital status, employer or school, and emergency contact, is documented

### 2) Documentation


- All entries include the signature or initials and title of the author
- All entries are dated with the month, day, and year
- Medical record entries are documented at the time service
- Documentation is objective, clear, and concise. The documentation supports the intensity of the patient evaluation, the treatment, and the medical decision-making
- Corrections are made by drawing a single line through the incorrect entry, writing the word "error", then write in the correct information near the original entry, sign/initial date and time the correction
- Patient corrections to the medical record are added as an addendum, without change or deletion to the original entry. The addendum is identified as such and added to the medical records at the direction of the patient

### 3) Medical Treatment/Planning

- Appropriate subjective and objective information pertinent to the patient's presenting symptoms is documented, as well as the history of present illness such as precipitating factors, possible causes, and length of time of symptoms or complaints
- Appropriate diagnostic tests are ordered and medical necessity of tests performed is supported by the documented evaluation of the patient's complaints and symptoms
- The documented diagnosis/treatment plan are consistent with the patient's presenting complaints and symptoms as well as the documented assessment
- A follow-up plan is documented for each encounter when indicated, and the specific time of return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed at subsequent visits
- Documentation reflects appropriate referral for consultation and there is a note from the consultant in the record indicating communication with the primary care physician or referring physician
- Consultant summaries, labs and imaging study results reflect primary care physician review through initialing of reports. Abnormal results have an explicit notation in the medical record of follow-up plans

### 4) Preventive Health

- For all patients 14 years and older (and younger as deemed appropriate by the practitioner) tobacco, alcohol and other substance use (both recreational and over the counter medications) are documented
- Immunizations are recorded and up-to-date and recorded into immunization registries where available
- There is documentation that preventive screening and services are offered to the patient in accordance with the Preventive Health Guidelines



# Problem List Guidelines

- Physician initiates and maintains for each patient by the third visit
- Physician/staff are responsible for updating with each encounter
- Assists with continuity and care coordination
- Medical record documentation is reflective of current problem list
- Easily identifies co-morbidities with consulting physicians
- Provides a “snapshot” of each patient