

1 **Clinical Practice Guideline: Medical Record Documentation**

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3 **Date of Implementation: September 20, 2007**

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5 **Product: Specialty**

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8 Consistent with the American Specialty Health – Specialty (ASH) commitment to quality  
 9 patient care, ASH has established medical record standards to ensure efficient, effective,  
 10 and complete clinical documentation practices. Appropriate medical/clinical record  
 11 documentation and maintenance practices are an integral component of a practitioner’s  
 12 practice. Entries in the medical record should be contemporaneous and made in a  
 13 chronological, systematic, and organized manner.

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15 ASH approved the following medical record documentation standards as constructive  
 16 guidance and education so that practitioners understand the quality requirements and  
 17 practice parameters of ASH. Medical record evaluation criteria are developed from  
 18 ASH’s approved practice parameters and evaluation criteria.

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20 Record keeping is an essential component of patient management, as it documents  
 21 procedures performed and patient response to care and acts as a basis for ongoing clinical  
 22 decision-making.

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<b>MEDICAL RECORD DOCUMENTATION CRITERIA</b>	
<b>Standard</b>	<b>Performance Measure</b>
Medical Records are maintained and stored in a manner which protects the safety of the records, the confidentiality of the information, and in accordance with state and federal (e.g., HIPAA) standards	Medical records are stored away from public access and easily accessible to only authorized staff and the clinician. The office should also maintain a written policy for the confidentiality of the medical/clinical records and staff should receive periodic training in confidentiality of patient information.

<b>MEDICAL RECORD DOCUMENTATION CRITERIA</b>	
<b>Standard</b>	<b>Performance Measure</b>
Individual Record	A medical record is maintained for each individual patient/client. Group or family records are not acceptable.
Legible <sup>1</sup>	Entries must be legible when reviewed by someone other than the author. Only standard abbreviations should be used. If additional abbreviations are used, a key defining these abbreviations should be maintained in each patient/client's medical record.
Daily Records Dated	Each entry must be dated.
Patient/Client Identification	So that medical records within the office, as well as those shared with another entity (e.g., physician, insurance, attorney), are clearly identified, each individual record must identify the patient/client, and each page in the medical record must contain the patient/client's name and/or identification number.
Practitioner Identification	Each entry clearly identifies (e.g., initials, signature) the practitioner providing the evaluation or procedure, including if the only practitioner in the office.
Biographical Information	Each record contains biographical information pertaining to the patient/client including, but not limited to: name, age or birthdate, address, telephone number and employer.
Past Medical History	The patient/client's prior medical, familial, and social history must be noted in the record. This includes, but is not limited to: accidents, surgeries, medications, allergies, illnesses and co-morbidities.
Tobacco, Alcohol, and Drug Abuse/Use	The use of tobacco, alcohol, and/or illicit drugs plays an important role in assessing a patient's health as well as provides an opportunity for the practitioner to encourage behavioral changes when indicated. There is an appropriate notation concerning the use of tobacco, alcohol, and substance use/abuse in the medical record.
Chief Complaint/Problem List	The patient/client's chief complaint(s), problem list, or purpose for visit must be documented in the medical record.
History and Physical Examination/ Evaluation of Chief Complaint	The history and physical examination/evaluation documents appropriate subjective and objective information pertinent to the patient/client's presenting complaint(s), related areas, and/or systems.

<b>MEDICAL RECORD DOCUMENTATION CRITERIA</b>	
<b>Standard</b>	<b>Performance Measure</b>
Diagnostic test and imaging reports reflect practitioner review	Results/reports of diagnostic tests and imaging (when ordered or performed) are documented in the medical record and reflect review by the practitioner as evidenced by the date and practitioner's signature or initials.
Diagnosis/Symptom Description*	The working diagnosis(es)/symptom description must be documented and consistent with the findings and patient/client's chief complaint(s).
Treatment Plan is consistent with diagnosis*	A treatment plan defines the therapeutic intervention(s), education, and/or self-care instructions provided or recommended to the patient. The treatment plan must be documented and consistent with the natural history of the diagnosed/assessed condition. When treatment includes therapeutic intervention(s), the medical record should reflect the therapy applied, location, duration, and patient/client's tolerance or response to the therapy.
Risks/Contraindications*	Contraindications include any circumstance which renders a form of treatment or clinical intervention inappropriate because it places the patient/client at undue risk. The medical record reflects that contraindications to care are appropriately identified and managed.
Continuity and Coordination of Care	There should be documentation of coordination of care between the practitioner and the patient's primary care physician or other specialty practitioner(s), as appropriate
Daily Records/SOAP Notes	The patient/client's medical record must be sufficiently complete to provide reasonable information to a subsequent health care practitioner. The daily records, at a minimum, must contain appropriate clinical documentation for each visit, including date, subjective complaints, objective findings that support the services rendered on that date, assessment of the patient's status/progress, diagnostic impression, therapeutic intervention(s) provided during the visit, recommendations and instructions given to the patient, and follow-up recommendations.
Re-Evaluations	A re-evaluation of a patient currently undergoing a course of care from a practitioner is considered medically necessary and may include: <ul style="list-style-type: none"> <li>• Establish refinement of the working diagnosis;</li> </ul>

<b>MEDICAL RECORD DOCUMENTATION CRITERIA</b>	
Standard	Performance Measure
	<ul style="list-style-type: none"> <li>• Re-evaluate possible impact of occupational, social and/or psycho-social issues that may impact care;</li> <li>• Monitor patient response following a reasonable trial of care;</li> <li>• Determine any necessary modifications to the plan of care including:                             <ul style="list-style-type: none"> <li>○ The need for additional diagnostic testing;</li> <li>○ Changes to treatment interventions;</li> <li>○ Readiness for discharge from care;</li> <li>○ New or further trauma or injury; and/or</li> <li>○ The need for referral to other healthcare practitioner(s) for evaluation, management, co-management, or coordination of care.</li> </ul> </li> </ul> <p>A re-evaluation of a patient undergoing care of a practitioner may be necessary for appropriate documentation; for more information, see Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations - CPG 111.</p>
Outcome Tools	An outcome tool is a procedure or method of measuring a change in patient status over time, primarily to evaluate the effect of treatment. Outcome tools (pain drawings, visual analog scale, etc.) are implemented as baselines for new patients/clients, exacerbations of returning patients/clients, and periodically to document the effect of treatment.
Self Care	Recommendations for exercise, self care, and general public health education are documented (e.g., dietary modification, cold pack application).
Preventive Services/Risk Screening	There is evidence that preventive services are recommended as appropriate to patients' age, gender, and clinical condition.

- 1 \*NCQA Critical Element as defined in NCQA audit-assist documents.
- 2 <sup>1</sup>Legibility includes that if the medical record is documented in any language other than English, the
- 3 practitioner must have the medical record translated into English prior to submitting copies to any
- 4 requesting third party, including but not limited to the patient/client, another health care practitioner,
- 5 insurance carrier, or attorney.

1 **References**

2 American Dietetic Association. (2008) *International Dietetics & Nutrition Terminology*  
3 (*IDNT*) *Reference Manual* (1<sup>st</sup> ed). Chicago: Author.

4  
5 American Physical Therapy Association. (2003) *Guide to physical therapist practice* (2<sup>nd</sup>  
6 ed). Alexandria, VA: Author.

7  
8 Bates, B. (1991). *A guide to physical examination and history taking* (5<sup>th</sup> ed).  
9 Philadelphia: J. B. Lippincott.

10  
11 Boissonnault, W. G. (Ed.). (1995). *Examination in physical therapy practice: Screening*  
12 *for medical disease* (2<sup>nd</sup> ed). Philadelphia: Churchstone Living.

13  
14 Chaitow, L., Fritz, S. & Hymel, G. (2007) *Clinical Massage in the Healthcare Setting*. St.  
15 Louis, MO: Mosby.

16  
17 Charney, P. & Malone, A. (Eds.). (2004) American Dietetic Association Pocket Guide to  
18 Nutrition Assessment. Chicago: American Dietetic Association.

19  
20 Colby, L. A. & Kisner, C. (1990) *Therapeutic exercise: Foundations and techniques* (2<sup>nd</sup>  
21 ed). Philadelphia: F. A. Davis.

22  
23 DeLee, J. C. & Drez, D., Jr. (1994). *Orthopaedic sports medicine: Principles and*  
24 *Practice* (Vols. 1-2). Philadelphia: W. B. Saunders.

25  
26 DeLee, J. C. & Drez, D., Jr. & Stanitski, C. L. (1994). *Pediatric and adolescent sports*  
27 *medicine* (Vol. 3). Philadelphia: W. B. Saunders.

28  
29 Donatelli, R. & Wooden, M. J. (Eds.). (1994) *Orthopaedic Physical Therapy* (2<sup>nd</sup> ed).  
30 New York: Churchill Livingstone.

31  
32 Duesterhaus Minor, & M. A., Duesterhaus Minor, S. (1995) *Patient care skills* (3<sup>rd</sup> ed).  
33 East Norwalk, CT: Appleton and Lange.

34  
35 Escott-Stump, S. (2002). *Nutrition and diagnosis related care* (5th ed.). Baltimore:  
36 Williams and Wilkins.

37  
38 Fritz, S. (2004). *Mosby's fundamentals of therapeutic massage* (3<sup>rd</sup> ed). St. Louis, MO:  
39 Mosby.

- 1 Haldeman, S., Chapman-Smith, D., & Petersen, D. M. (Eds.). (1993). *Guidelines for*  
 2 *chiropractic quality assurance and practice parameters: proceedings of the*  
 3 *Mercy Center Consensus Conference*. Gaithersburg, MD: Aspen Publishers.
- 4
- 5 Joint Commission on Accreditation of Healthcare Organizations. (2000). *2000 Hospital*  
 6 *accreditation standards*. Oakbrook Terrace, IL: Author.
- 7
- 8 Kettenback, G. (1995). *Writing SOAP notes* (2<sup>nd</sup> ed). Philadelphia: F. A. Davis.
- 9
- 10 Magee, D. J. (1997). *Orthopedic Physical Assessment* (3<sup>rd</sup> ed). Philadelphia: W. B.  
 11 Saunders.
- 12
- 13 Mahan, L. K., & Escott-Stump, S. (2003). *Krause's food, nutrition and diet therapy* (11th  
 14 ed.). Philadelphia. W.B Saunders.
- 15
- 16 Nolan, M. F. (1996) *Introduction to the neurologic examination*. Philadelphia: F. A.  
 17 Davis.
- 18
- 19 Nosse, L. J., & Friberg, D. G. (1992). *Management principles for physical therapists*.  
 20 Baltimore: Williams and Wilkins.
- 21
- 22 Richardson, J. K. & Iglarsh, Z. A. (1994) *Clinical Orthopaedic Physical Therapy*.  
 23 Philadelphia: W. B. Saunders.
- 24
- 25 Seare, J. G. (1995). *Medical documentation: streamlining an essential clinical process*.  
 26 Salt Lake City, UT: Medicode.
- 27
- 28 Shils, M., Olson, J., Shike, M., & Ross, C. A. (2005). *Modern nutrition in health and*  
 29 *disease* (10th ed.). Baltimore: Lippincott Williams and Wilkins.
- 30
- 31 Thompson, D. L. (2006). *Hands heal: communication, documentation and insurance*  
 32 *billing for manual therapists* (3<sup>rd</sup> ed). Philadelphia: Lippincott Williams and  
 33 Wilkins.
- 34
- 35 Umphred, D. A. (Ed.). (1985). *Neurological Rehabilitation*. St. Louis, MO: Mosby.