

TEN PRINCIPLES OF DOCUMENTATION FOR MEDICAL RECORDS

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include
 - The date;
 - The reason for the encounter;
 - Appropriate history and physical exam in relationship to the patient's chief complaint;
 - Review of lab, x-ray data and other ancillary services, where appropriate;
 - Assessment; and
 - Plan for care (including discharge plan, if appropriate)
3. Past and present diagnoses should be accessible to the treating and/or consulting physician
4. The reasons for – and results of – x-rays, lab tests and other ancillary services should be documented and included in the medical record
5. Relevant health risk factors should be identified
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient non-compliance, should be documented
7. The written plan for care should include, when appropriate:
 - Treatments and medications, specifying frequency and dosage;
 - Any referrals and consultations;
 - Patient/family education; and
 - Specific instructions for follow up
8. The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of the medical decision-making as it relates to the patient's chief complaint for the encounter
9. All entries to the medical record should be dated and authenticated
10. The CPT/ICD-9-CM codes reported on the CMS-1500 claim form should reflect the documentation in the medical record

From the Centers for Medicare and Medicaid Services and TrailBlazer Health Enterprises, LLC