

1 **Clinical Practice Guideline:** **Medical Record Documentation**
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 3 **Date of Implementation:** **September 20, 2007**
 4
 5 **Contact:** **Clinical Care Management**
 6 **Clinical Quality Management**
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9 Consistent with the American Specialty Health Affiliates’ (ASHA) commitment to
 10 quality patient care, ASHA has established medical record standards to ensure efficient,
 11 effective, and complete clinical documentation practices. Appropriate medical/clinical
 12 record documentation and maintenance practices are an integral component of a
 13 practitioner’s practice. Entries in the medical record should be contemporaneous and
 14 made in a chronological, systematic, and organized manner.
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16 ASHA approved the following medical record documentation standards as constructive
 17 guidance and education so that practitioners understand the quality requirements and
 18 practice parameters of ASHA. Medical record evaluation criteria are developed from
 19 ASHA’s approved practice parameters and evaluation criteria.
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21 Record keeping is an essential component of patient management, as it documents
 22 procedures performed and patient response to care and acts as a basis for ongoing clinical
 23 decision-making.
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MEDICAL RECORD DOCUMENTATION CRITERIA	
Standard	Performance Measure
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.
Individual Record	A medical record is maintained for each individual patient/client. Group or family records are not acceptable.
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.

MEDICAL RECORD DOCUMENTATION CRITERIA

Standard	Performance Measure
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, illnesses and co-morbidities.
Tobacco, Alcohol, and Drug Abuse/Use	The use of tobacco, alcohol, and/or illicit drugs plays an important roll 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.
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.
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.
Chief Complaint/Problem List	The patient/client's chief complaint(s), problem list, or purpose for visit must be documented in the medical record.
Diagnosis/Symptom Description*	The working diagnosis(es)/symptom description must be documented and consistent with the findings and patient/client's chief complaint(s).
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.
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.
Preventive Services/Risk	There is evidence that preventive services are recommended as

MEDICAL RECORD DOCUMENTATION CRITERIA

Standard	Performance Measure
Screening	appropriate to patients' age, gender, and clinical condition.
Legible ¹	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.
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.
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.
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.
Self Care	Recommendations for exercise, self care, and general public health education are documented (e.g., dietary modification, cold pack application).
Re-Evaluations	A re-evaluation of a patient currently undergoing a course of care from a provider is considered medically necessary to: <ul style="list-style-type: none"> • Establish refinement of the working diagnosis;

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Standard	Performance Measure
	<ul style="list-style-type: none"> • Re-evaluate possible impact of physical (including occupational), social, and/or psycho-social issues that may impact care; • Monitor patient response to the plan of care; or • Determine necessary modifications to the plan of care such as diagnostic testing, changes to interventions, or appropriateness of referral or discharge.

1 *NCQA Critical Element as defined in NCQA audit-assist documents.
 2 ¹Legibility 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.
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