Documentation Standards

General Standards

The documentation standards listed below applv to ALL medical records

1. Patient's name

    - The patient's first and last name should appear on one side of each page in the medial record.

2. Patient's personal biographical information is in the medical record.
   (Either DOB or age AND gender)

    - For compliance, the Patient's DOB should be documented either in their demographic information and/or within the office visit notes at least once in the calendar year
    - OR their age is documented in the office notes at least once in the calendar year
    - AND their gender is documented on the demographic sheet or in the office notes at least once in the calendar year.

3. Personal contact information and marital status is in the medical record.

    - For children/minors, the home and/or work numbers for the parents/guardians/case workers must be in the medical record.
    - For adults, the primary phone number is documented in the medical record OR there is documentation that they do not have a phone.
    - For adults, marital status must be documented in some prominent location in the medical record. Acceptable entries include, married, separated, divorced, widowed, never married, single, or that the patient lives alone.

4. Legal guardianship (if applicable)

    - Guardianship is defined as giving legal right to another person to be responsible for food, healthcare, housing and other necessities of a person deemed fully or partially incapable of providing these necessities for themselves.
    - Documentation can be anywhere in the medical record.

5. HIPAA release in the medical record

    - A HIPAA protected health release form is required to be completed for every patient.
    - Parents should sign a HIPAA release for minors.

6. Record is legible to someone other than the writer and is in standard English.

    - EMR/EHR's will be compliant.
    - If the record contains hand-written notes, they must be legible to people outside of the provider's office.
    - For compliance with the NYS criteria; the handwritten sections of the medical record are possible to read and/or decipher or the medical record reviewer is able to determine an answer to the majority of the measurement criteria by reading the record.

7. Allergies

    - The medical record must contain documentation of allergies or a lack of allergies/no known allergies.

8. Adverse reaction to drugs

    - The medical record must list the patient's adverse reactions to medications/drug therapy.

9. Language spoken

    - The medical record must contain documentation that the patient or their care giver speaks English, OR
    - The medical record documents the patient or primary caregiver's primary language spoken (which is not English) AND the medical record contains information that the provider either speaks the primary language (it cannot be assumed that the provider speaks the language, it must be documented) or offered translation services, OR
    - If the medical record contains no documentation that the patient or caregiver speaks anything but English and there are NO records, forms or educational materials in another language it can be assumed the patient speaks English. (E.g. if the patient's registration form is in any language but English {such as Spanish, Mandarin, Russian, etc.} and the chart does not document that they can speak English OR, that interpreter services were provided, the chart is non-compliant).

10. Current medication list

    - The medical records must have a list of medications that the patient is taking. Include prescribed medications, supplements, or over the counter (OTC) drugs.
    - The list may be on a form or in the office notes.
    - If there is a previous list, there must be a notation that it was reviewed.

11. Current diagnosis/problem list

    - The medical records must contain a current/updated diagnosis or problem list.

12. Complete summary of surgical procedures, if applicable

    - The medical record will not be compliant if a partial surgical list is identified. (E.g. there is a list of surgeries in the medical record, but on review of the office notes, one or more surgeries are identified that are not on the list).
    - If the patient has not had any surgeries, this should be documented in the chart.

13. Age appropriate lifestyle and risk counseling (including family planning)

    - Lifestyle and risk counseling are educational efforts by the provider addressing lifestyle choices that predispose the patient to increased health risks.

- Family planning can include education on birth control and other matters such as choosing when to have children.
- Note: the most common risky behaviors that are considered here are; obesity, sedentary lifestyle, poor nutrition, and risky sexual behaviors.

14. Documentation of screening for tobacco, alcohol OR drug abuse with appropriate counseling/referrals if needed. For patients 11years and older.

    - The medical records should have evidence of an assessment and if use is documented, evidence of counseling or referral for services.

15. Documentation of screening for domestic violence

    - Documentation that the patient lives alone will NOT make the record compliant, as people from outside the home may be threatening or hurting the patient.
    - If the screening is positive for domestic violence, there should be documentation of a referral for additional services.

16. Documentation that patients, 18 and older, where provided written information regarding advanced directives

    - Living will, health care proxy or a durable power of attorney will meet.
    - It should be documented if the patient refused the information.

17. Each entry should contain an assessment of present health history and past medical history.

18. Chief complaint- Subjective

    - The chief (presenting) complaint should be the symptom or group of symptoms about which the patient first consults their doctor; the presenting symptom (does not apply to well visits, preventative visits or annual exams).

19. Physical exam

    - During an acute visit the physical exam could involve one or more body parts or systems.
    - During a preventative visit the physical exam should involve 5 of the 10 components of a physical exam.

20. Treatment plan is consistent with findings

    - Every visit should have the treatment plan documented in the medical record.

21. Disposition, recommendations and/or instructions provided to the patient (one of the following will make the chart compliant

    - Visit contains documentation that the member was provided with a prescription for medications

or to get tests, OR
- Visit contains documentation that the member was contacted with results, OR
- Visit contains documentation that the member was to schedule a follow up visit or call back if the problem persists, OR
- Visit contains documentation that the member was instructed to complete an activity for anything pertaining to the visit.

22. Evidence of a follow up visit

- If appropriate, the record should contain evidence of a follow up visit.

23. Each entry is signed by the provider

- Signature may be handwritten or a unique electronic identifier.
- Every signature must have an identifiable professional delineation.

24. Each entry is dated.

25. Studies such as x-rays, labs, consults etc. are reviewed by the provider and placed in the record

- Reviewed studies must be signed or initialed by the provider who reviewed them.
- If using an EMR, the signature or initials should be identifiable to someone reviewing either an electronic version of the records, or a printed hard copy.

26. Appropriate medically indicated follow up after ER visits and hospital discharge

- If follow up is recommended by the hospital or ER after discharge, the chart should reflect the follow up within the recommended timeframes.

27. Patient education

- The medical record should reflect patient education. Either verbal or written education or instructions as appropriate are compliant.
- Significant medical advice given via telephone should be entered into the record and signed or initialed and will be complaint (including after-hours telephone services.)

28. Assessment, counseling or education on risk behaviors and preventive actions associated with sexual activity

- Examples of complaint documentation:
  - Notation of assessment of current behaviors (abstinent, sexually active)
  - Use of a checklist indicating sexual behaviors were discussed.
  - Assessment, counseling or referral for HIV, STDs or pregnancy
  - Prescription or dispensing for contraceptives WITH any of the above mentioned assessments
  - Discussion offset", "safe dating"

- Documentation of providing educational materials specifically geared towards risk behaviors and preventative actions

29. Documentation in the medical record of assessment or counseling or education on depression

- Examples of complaint documentation:
  - A health assessment form about the adolescent's depressive symptoms
  - Assessment of behavior and mood
  - Use of a checklist indicating that depression or symptoms of depression were assessed
  - Inquiry of depression, or inquiry of whether the patient felt down, depressed, hopeless, has suicidal ideation, or is feeling little interest or pleasure in doing things
  - Diagnosis of depression or prescriptions for antidepressants or discussion of prescriptions for depression
  - Education (including distribution of educational materials) or counseling for symptoms of depression or where to get help (referral)

30. Documentation in the medical record of assessment or counseling or education about the risks of tobacco use, which include, but not limited to, cigarettes, chew or cigars

- Notation about current or past tobacco use
- Notation of counseling or treatment referral or providing educational materials for tobacco use
- Notation of prescription for smoking cessation medication
- Notation of discussion about exposure to secondhand smoke

31. Documentation in the record of an assessment or counseling or education about the risks of substance abuse. Including but not limited to, alcohol, street drugs, non-prescription drugs, prescription drug misuse and inhalant use.

- Include documentation of past and present use.
- Documentation of counseling or treatment referrals or distribution of educational materials