Clinical Practice Guideline: **Medical Record Maintenance and Documentation Practices**

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

Product: **Specialty**

Related Policies:
CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care
CPG 102: Radiographic Quality and Safety Parameters
CPG 111: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations
CPG 135: Physical Therapy Medical Policy/Guideline
CPG 155: Occupational Therapy Medical Policy/Guideline
CPG 166: Speech-Language Pathology/Speech Therapy Guidelines
CPG 167: Therapeutic Massage Medical Policy/Guideline
CPG 175: Extra-Spinal Manipulation/Mobilization for the Treatment of Upper Extremity Musculoskeletal Conditions
CPG 177: Extra-Spinal Manipulation/Mobilization for the Treatment of Lower Extremity Musculoskeletal Conditions
CPG 264: Acupuncture Services
CPG 278: Chiropractic Services Medical Policy/Guideline

GUIDELINES

Consistent with the American Specialty Health – Specialty (ASH) commitment to quality patient care, ASH has established medical record standards to promote efficient, effective, and complete clinical documentation practices. Appropriate medical record maintenance and documentation practices are an integral component of a practitioner's practice. Entries in the medical record should be contemporaneous, appropriately comprehensive and made in a chronological, systematic, and organized manner. Medical records must comply with ASH guidelines, as well as, all applicable federal and state statutes and regulations in accordance with standards set forth for the licensed practitioner's specialty and facility type.

Medical record keeping is an essential component of patient evaluation and management, as it documents critical elements, such as:

- History and examination findings;
- Treatment planning and goals;
- Coordination of care;
- Diagnostic studies;
- Procedures;
- Patient response to care;
- Functional Outcome Measure/Patient Reported Outcome Measure; and

- On-going reevaluation and decision-making.

ASH adopted the following medical record documentation and maintenance practices as constructive guidance and education so that practitioners understand the quality requirements and practice parameters of ASH. All of the elements are important for most cases; however, the required elements will vary as it applies to the practitioner's scope of practice.

MEDICAL RECORD MAINTENANCE AND DOCUMENTATION PRACTICES	
Element	**Description**
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.
Centers for Medicare and Medicaid Services (CMS)	For Medicare and Medicaid patients, medical record keeping should always be in accordance with CMS documentation guidelines.
Current State Statutes and Regulations	All licensed practitioners and facilities must comply with all applicable state statutes and regulations.
American Medical Association (AMA) Current Procedural Terminology (CPT)	Medical record keeping and billing practices should always be in accordance with current AMA CPT coding guidelines.
Individual Record	A medical record is maintained for each individual patient/client. Group or family records are not acceptable.
Untimed Vs. Timed CPT Codes	Medical records must accurately reflect all services rendered and billed. Physical Medicine and Rehabilitation modality and therapeutic procedural CPT codes are either untimed (service based) or timed (constant attendance). Untimed codes are reported as one unit per day. (1 or more areas) Timed codes are reported using either the CMS or AMA 8-minute rule.
Informed Consent for Services	Prior to the delivery of any services, the health care practitioner should obtain consent from the patient. The consent must be documented in the patient's medical record.
Legibility	All entries must be legible when reviewed by someone other than the author. Only standard abbreviations should be used. If additional

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	abbreviations are used, a key defining these abbreviations must be maintained in each patient/client's medical record. Legibility includes that if the medical record is documented in any language other than English, the practitioner must have the medical record translated into English prior to submitting copies to ASH and/or any requesting third party, including but not limited to the patient/client, another health care practitioner, insurance carrier, or attorney.
All Entries Are Accurately Dated	Each entry must be dated with the date service was rendered.
Patient/Client Identification	In order to ensure 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 (initials, unique electronic identifier or handwritten signature) the practitioner providing the evaluation or procedure, even when there is only one practitioner in the office. Medical records must be initialed or signed by the rendering practitioner within a time reasonably proximate to the evaluation or treatment documented in the medical record, which ASH considers to be within 72 hours of the patient visit.
Biographical Information	Each record contains biographical information pertaining to the patient/client including, but not limited to: name, age or birthdate, address, telephone number(s), employer and marital status.
Past Medical History	The patient/client's prior medical, familial, and social history must be easily identified in the record. This includes, but is not limited to: serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
Immunizations	An immunization record (for children) is up to date or an appropriate history of immunizations has been documented in the medical record (for adults).
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 disorder in the medical record.

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Chief Complaint/Problem List	The patient/client's chief complaint(s), problem list, or purpose for visit must be documented in the medical record. Significant illnesses and medical conditions are also indicated on the problem list. (Refer to *CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care* for additional information.)
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. (Refer to *CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care* for additional information.)
Professionally Recognized Terminology, Tests and Measures	The use of non-standard terms or abbreviations complicate communication and not using appropriate examination tests and measures creates barriers to describe objective impairments and treatment effectiveness. Professionally recognized clinical terminology and valid examination tests and measures, such as grading scales, should be used that are in accordance with the standards set forth for the licensed practitioner's specialty, training and scope of practice. The following are examples of neuromusculoskeletal grading scales that may be used for initial assessment and can also be used as outcome measures: 1. The Oxford or other standard manual muscle testing procedures (i.e., Reese, Daniels and Worthingham) 0-5 scale to assess muscle strength, with no contraction/action present at 0 and 5 when muscle function is normal for that person. 2. Response levels of deep tendon reflexes graded using the Wexler 0-5^+ scale, with 2^+ being normal. Note that deep tendon reflexes are normal if they are 1^+, 2^+, or 3^+ unless they are asymmetric or there is a dramatic difference between the arms and the legs. Reflexes rated as 0, 4^+, or 5^+ are usually considered abnormal. 3. The 1-4, grading scale may be used for tenderness when palpating: ▪ Grade I – patient complains of pain ▪ Grade II – patient complains of pain and winces ▪ Grade III – patient winces and withdraws the joint ▪ Grade IV – patient will not allow palpation of the joint
Laboratory and Other Diagnostic Studies	Laboratory and Other Diagnostic Studies are ordered, as appropriate.

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Diagnostic studies, imaging reports and consultations 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 who ordered them, as evidenced by the date and the practitioner's initials, unique electronic identifier or handwritten signature. Review and signature by professionals other than the ordering practitioner do not meet this requirement. Consultation and abnormal diagnostic and imaging study results have an explicit notation in the record of follow-up plans and discussion with the patient. (Refer to *CPG 102: Radiographic Quality and Safety Parameters* for additional information.)
Diagnosis/Symptom Description	The working diagnosis(es)/symptom(s) description must be documented and consistent with the findings and patient/client's chief complaint(s).
Patient-Centered Care Planning	Medical records should reflect patient-centered care planning. The use of generic care plans is not keeping with the objective for shared and individualized care planning. Efforts must be made for care plans to reflect individualization, personalization, collaboration and promote patient empowerment through appropriate self-care strategies. Care planning relative to Treatment Frequency and Duration should be individualized and propose a reasonable frequency and generally predicable period of time relevant to the patient and condition.
Treatment Plan is consistent with diagnosis	A treatment plan defines the therapeutic intervention(s), goals set, 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 and progress towards stated goals. (Refer to *CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care* for additional information.)
Treatment Goals	Each care plan should enable the practitioner(s) providing care to meet the assessed needs/goals of the person receiving care. The care plan must be current, accurate and evidenced based, with SMART (Specific, Measurable, Achievable, Realistic and Timed) objectives.
Medications, Allergies and Adverse Reactions	Medications, allergies and adverse reactions are promptly noted in the record. If the patient has no known allergies, or history of adverse reactions, this is appropriately noted in the record.

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Risks/Contraindications	There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. The medical record reflects that any contraindication(s) to care are appropriately identified and managed. (Refer *to CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care* for additional information.)
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.
Consultations	If a consultation is requested, there is a note from the consultant in the record and documentation supporting the medical necessity of the consultation, as well as evidence of review of the report by the practitioner.
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 including the location, duration, and patient/client's tolerance or response to the intervention(s), progress towards stated goals, recommendations and instructions given to the patient, and follow-up care, calls or visits, when indicated. The specific time of return is noted in days, weeks, months or as needed.
Unresolved Problems	Unresolved Problems from previous office visits are addressed in each subsequent visit record.
Re-Evaluations	During a course of care with a practitioner, re-evaluation of the patient may be necessary. The documentation of re-evaluations should be consistent with the criteria outlined in the ASH Clinical Practice Guideline (CPG) titled *Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations - CPG 111*.
Outcome Tools/Functional Outcome Measure	An outcome tool or functional outcome measure is a valid and reliable way of measuring a change in patient status over time, primarily to evaluate the effect of treatment. Outcome tools (visual analog scale, Oswestry, LEFS, NDI, SPADI, etc.) are implemented as baselines for new patients/clients, exacerbations of returning patients/clients, and periodically to document the effect of treatment.

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Self-Care	Recommendations for exercise, self-care, and general public health education are documented (e.g., dietary modification, cold pack application).
Preventive Screening and Services	There is evidence that preventive screening and services are recommended in accordance with applicable ASH Clinical Practice Guidelines.

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