

Medical Record Documentation

Policy

It is the policy of UTM&B to initiate and maintain a complete and accurate medical record for every individual assessed, cared for, treated, or served. Documentation in the medical record shall be sufficient to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among health care providers. Medical record documentation is to be timely, meaningful, authenticated, and legible. All relevant documents and entries should be entered into the medical record at the time the service is rendered. The electronic medical record (EMR) must be used for documentation in all areas where its implementation has been completed.

Every individual documenting in the medical record is responsible for the entire content of his/her documentation, whether the content is original, copied, pasted, imported or reused. Those who document are responsible for the accuracy, medical necessity, and documentation requirements of each of their notes.

In addition, they are responsible for the proper maintenance of their basket by reviewing it regularly to prevent delinquencies in the medical record. Faculty members should ensure that resident notes are accurate and consistent with this policy at the time of co-signing any note.

More specific documentation requirements can be found in the [Medical Staff Bylaws, Medical Staff Rules and Regulations](#), and the booklet, "The Medical Record and Health Information Management Services" published by the Department of Health Information Management (HIM).

Legibility

1. All entries must be legible, including handwritten/electronic signatures.
2. Black ink is recommended for hardcopy medical record entries.

Patient Identification

1. Every page in the medical record or electronic medical record screen must be identifiable by patient name and complete medical record number (including the alpha suffix). It is preferred that this information be available on both sides of a document.
2. If the Department of Health Information Management (HIM) receives documents with incomplete, illegible and/or missing patient identification, an attempt will be made to properly identify the patient. Documents successfully identified will be

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CL Gary

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Documentation Sourcebook Chris E. Stout,1999-11-17 All the forms handouts and records you need to meet the paperwork requirements of the managed care era In an era of third party accountability your professional survival could hinge on your ability to comply with the documentation requirements of insurers and regulatory agencies Written by an experienced clinician who has trained thousands of mental health professionals in effective clinical documentation this sourcebook helps you minimize the potential for billing disputes or worse by arming you with the full retinue of required forms checklists and records An indispensable resource for mental health professionals working in inpatient partial hospitalization day treatment and or residential treatment programs The Continuum of Care Clinical Documentation Sourcebook is the only book that brings together sample documents covering all stages of treatment from intake and admission to outcome assessment Ready to use blank forms handouts and records make it easy to satisfy the paperwork demands of HMOs insurers and regulatory agencies Completed copies of forms illustrate the exact type of information required Clear concise explanations of the purpose of each form including when it should be used with whom and at what point Forms may be copied from the book or customized on the included disk **Medical Record** Ernest Abraham Hart,1886

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