Scripps | Health Plan Services

Medical Record Documentation Standards Tip Sheet

Documentation should meet all federal and state legal, regulatory, and accreditation requirements. Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. There are specific elements that reflect a set of commonly accepted standards for medical record documentation.

- Each page or electronic medical record contains a member name, identification (ID), or medical record number (MRN).
- All entries in the medical record contain the author's identification. Author identification may be a signature, unique electronic identifier, or initials.
- All entries in the medical record are dated.
- Allergy list and adverse reactions are prominently noted in the chart or electronic medical record (EMR). If there are no known drug allergies or history of adverse reactions, this is noted in the record.
- All medications included in the treatment plan for an encounter is present or updated in the medication list.
- Significant illnesses and medical conditions are indicated in the problem list.
- An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
- Past medical history is easily identified in the chart or EMR and includes serious accidents, operations, and illnesses. For children and adolescents (younger than18 years), the past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with findings.
- Documentation of preventive screening, services, and education are offered in accordance with clinical guidelines specific to member's age, gender, or illness.
- Documentation that treatment goals were established and communicated to the member.
- Documentation of the barrier to member compliance with prescribed treatments and regimens and interventions to address these barriers to care.
- Documentation that demonstrates continuity and coordination of care between and among providers, including medical, mental health, and maternal mental health providers.
- Documentation demonstrates no evidence that the member is placed at inappropriate risk by a diagnostic or treatment procedure.
- Documentation of an Advanced Directive or counseling offered if member is 18 years old and over.
- If a specialist visit is requested, there is documentation of feedback from the specialist to the primary care physician (PCP) within fourteen (14) calendar days of the specialist visit.
- Clinical documentation matches/supports orders and referrals entered in system.

- Documentation of all members of the care team.
- Documentation of care coordination between other providers in the care team.
- Medical records should be readily available for release to other treating providers and to support continuity of care.
- Providers should be familiar with additional requirements within their respective medical practices and/or Medical Staff Rules and Regulations for hospital encounters.