

ARIZONA PRIORITY CARE COLD STANDARDS FOR MEDICAL RECORD DOCUMENTATION					
MEDICAL RECORD CRITERIA	DOCUMENTATION TIPS	WHAT AUDITORS ARE LOOKING FOR			
 Ensure the medical record is legible and complete Reason for the encounter, relevant history, findings, test results and the date of service must be documented At least 2 patient identifiers need to be on each page of the record Records should not only substantiate the conditions and services performed but also the level of care Assessment and impression must be listed for each diagnosis (status + plan) Records must have a clearly legible provider signature as well as their credential Electronic signature must be stated as "Authenticated by", "Signed by", or "Approved by" and include the date, name and credentials of the authoring provider 	 Include a status and plan for each diagnoses being reported Don't use symbols in your documentation as these can be easily misunderstood and are not appropriate for use as support for a condition Don't write the diagnosis code in place of the narrative diagnosis Make sure all billed codes match what was documented for that specific date of service If you have paper charts and EMR, consider moving to EMR entirely Corrections must be made to both paper and electronic charts that clearly show a correction has been made as well as who made it Amendments to records should be made as close to the date of service as possible 	 Is the record LEGIBLE? Is the record complete? Does there appear to be cloning/copy and pasting issues within the EMR? EMR trending issues (automatically pulling forward diagnoses) Are all conditions/codes being submitted through the billing process? Were all validated conditions billed? Were all billed codes validated? Appropriate medical necessity? Appropriate level of care reported? Was the record signed with valid signature and credentials? Incident to requirement adherence? Does the provider who created the record match the provider on the claim? Is there any conflicting information? 			

REMEMBER THE	М	E	A	Т	
ACRONYM: MEAT	MONITORED	EVALUATED	ASSESSED	TREATED	
One of the 4 elements shown in the above acronym must be documented in the record in order to validate the diagnosis being reported and billed. Remember, "If it's not documented, it's not reportable".					
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AZPC Coding and Documentation materials are based on current guidelines and are to be used for reference only. Clinical and coding decisions are to be made based on the independent judgement of the treating physician or qualified health care practitioner and the best interests of the patient. ICD-10-CM, CPT and HCPCS are the authoritative references for purposes of assigning diagnoses and procedure codes to be reported. It is the responsibility of the physician and/or coding staff to determine and submit accurate codes, charges and modifiers for services rendered.