ARIZONA PRIORITY CARE | GOLD 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 ACRONYM: *MEAT*	*M* *MONITORED*	*E* *EVALUATED*	*A* *ASSESSED*	*T* *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".				