Medical Record Documentation Standards

Samaritan Health Plans requires that complete medical records are maintained for every member in accordance with accepted professional practice standards, state and federal requirements. Consistent and complete documentation in the patient's medical record ensures communication, coordination and continuity of care and promotes efficient and effective treatment.

Please see the following table for elements of and standards for appropriate medical record documentation. Core standards are indicated by an asterisk (*).

Element	Standard
Structure	
Patient identification	• Patient's name or identification number is included on each page in the record.*
Personal data	• The patient's address, employer, marital/partnership status and all applicable phone numbers are included. • The patient's self-reported race, ethnicity and preferred language are also documented.
Author's identification	• All entries identify the author. Author's identification may be handwritten signature, unique electronic identifier or initials. *
Dated entries	• Date of service must be on all entries.*
Medical history	
Problem list	• Medical conditions and significant illnesses are indicated on the problem list.*
Allergies and/or adverse reactions	• Allergies and/or adverse reactions to medications must be documented. If the patient has no known allergies and/or adverse reactions to drugs, this must be noted in the records.*
Medical history	• Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations and childhood illnesses.*
Medication list	A medication list must be present, including: • Medications. • Dosage. • Frequency. • Route. • Dates of initial and/or refill prescriptions.

	• Over-the-counter medications, herbal remedies, supplements, etc.
Immunization record	• An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
Advance directive	• There must be documentation stating whether or not a member has completed an advance directive (ages 18 and older). This documentation is required by the Centers for Medicare and Medicaid Services (CMS).
Medical care	
Chief complaint or purpose of visit	• The reason for patient encounter, and history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
Working diagnosis(es)	• Working diagnosis(es) are consistent with findings.*
Labs or other studies	• Laboratory and other studies are ordered, as appropriate.
Treatment plan	• Treatment plans are consistent with diagnosis(es).* • There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.*
Coordination of care	• Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed. • Unresolved problems from previous office visits are addressed in subsequent visits. • There is review for under or overutilization of consultants. • If a consultation is requested, there is a note from the consultant in the record. • Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
Preventive health/ risk screening	• There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines. (May not be applicable to some specialty practices.) • For patients 12 years and older, there are appropriate notes concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).

References:

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