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.

Element	Standard
Structure	
Organized in a consistent manner	• Clearly organized. • In chronological order. • Stored in a manner that allows for easy retrieval. • Does not contain information for other patients.
Legible entries	• Must be complete and legible to someone other than the author. • Content is presented in a standard format that allows a reader, other than the author, to review without using a separate legend/key.
Personal data	• The patient's name, 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.
Patient identification	• Patient's name or identification number must be included on each page.
Signatures, initials and credentials	• Author's signature must be legible and includes the author's professional credentials (stamps are not acceptable); may be automated by EMR system. • Initials may be used as long as the health care professional's credential is included.
Dated entries	• Date of service must be on all entries.

Medical history	
Medical problem list	A medical problem list must be present, including: • Past medical history. • Chronic or significant acute medical conditions. • Significant surgical conditions. • Significant behavioral health conditions. • For children and adolescents (18 years and younger), prenatal care, birth, surgery and childhood illnesses should be documented on this list.
Medication list	A medication list must be present, including: • Medications. • Dosage. • Frequency. • Dates of initial and/or refill prescriptions. • Over-the-counter medications, herbal remedies, supplements, etc.
Allergies and/or adverse reactions	• Allergies and/or adverse reactions to drugs must be documented. • If the patient has no known allergies and/or adverse reactions to drugs, this must be noted in the records.
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)	• Must be a confirmed diagnosis(es). • Laboratory and other studies are ordered, as appropriate. • Working diagnosis(es) are consistent with findings. • Past and present diagnoses should be accessible to the treating and/or consulting health care professional. • The patient's progress, response to and changes in treatment, and revision of diagnosis(es) should be documented. • 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. • Unresolved problems from previous office visits are addressed in subsequent visits.
Consult continuity of care	Must contain documented evidence of all referred diagnostic and therapeutic services, such as: • Physical therapy notes. • Emergency room records.

	• Hospital discharge summaries. • There is a review for under or overutilization of consultants. • If a consultation is requested, there is a note from the consultant in the record. • There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. • 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.
Coordination of care	• Must contain documented evidence of continuity and coordination of care for all ancillary services and diagnostic tests ordered by the health care professional. • 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.
Preventive health/Risk screening	• Must reflect recommendation of preventive care guidelines that are age appropriate. • For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history). • May not be applicable to some specialty practices.
Privacy	
Safety/Confidentiality of medical record	• Medical records must be stored in a secure location and protected from public access. • Office staff must receive periodic training in member information confidentiality.

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