



## **MEDICAL RECORDS REQUIREMENTS**

According to the Center for Medicare and Medicaid (CMS) clear and concise medical record documentation is critical to providing patients with quality care and is required for health care providers to receive accurate and timely payment for furnished services. Medical record documentation helps physician and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.

General Principles of medical record documentation apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, these general principles help ensure that medical record documentation for all E/M service is appropriate:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include
  - Patient's name
  - Date of Birth
  - Date of Service
  - Physician's name
  - Reason for the encounter and relevant history, physical exam findings, and prior diagnostics test results.
  - Assessment, clinical impression, or diagnosis.
  - Medical plan of care
  - If the rationale for ordering diagnostic and other ancillary services is not documented, it should be easily inferred.
  - Past and present diagnoses should be accessible to the treating and/or consulting physician.
  - Appropriate health risk factors should be identified.
  - The patient's progress, responses to and changes in treatment, and revision of diagnosis should be documented.
  - The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported in the medical record.
- The entire article can be found on CMS Medicare Benefit Policy Manual (Publication 100-02)