Medical Record Documentation: The Basics and Beyond

CDPHP® often reviews member medical records as needed to transact health plan business, as well as comply with regulatory agencies such as NCQA and CMS. We generally find that our network providers' documentation practices adequately fulfill basic standards of care; however, we occasionally identify opportunities for improvement.

Please be aware of the following documentation guidelines from CMS:

- The provider's *signature and credentials* must be on each chart entry, with the ***patient name and DOS on each page*** of the medical record.
- **Signatures and credentials** must be legible or written above a typed name.
- Electronic signatures must indicate "approved by", "signed by", or "electronically signed by" notations.
- Rubber stamp signatures are NOT acceptable. However, in the case of an author with a physical disability who can provide proof to a CMS contractor of their inability to sign, they will be permitted.
- When an error is made in the handwritten record, the provider must cross out the incorrect information with a single line, *initial and date the correction*, then write in the correct information (e.g., ~~with a single line~~).
- Handwritten charts should include a dynamic record of provider names, **signatures, and *credentials*.**
- ***Practice titles*** should be identified on each medical record.
- For accurate and complete diagnosis coding, always use the current version of ICD-10-CM and **follow standard coding guidelines.**

Thank you for your cooperation in meeting and exceeding the basics of best practice medical record documentation.

For more information about CMS regulations, visit the Medicare Learning Network at http://go.cms.gov/MLNProducts to access the following resources:

DHHS/CMS publication ICN 905364, October 2013
DHHS/CMS publication ICN 909160, November 2014
Optum Risk Adjustment Documentation, Coding & Quality Toolbook, September 2013