

TITLE: Documentation Requirements for the Medical Record			
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Facility: Banner Churchill Community Hospital			
Population (Define): Medical Staff			
Replaces:			
Approved by: Medical Executive Committee, Medical Staff, and Banner Board			

TITLE: *Documentation Requirements for the Medical Record*

I. Purpose/Expected Outcome:

- A. To ensure the documentation in the medical record meets generally accepted professional standards of documentation, specifically mandated regulatory, legal and/or accrediting standards and supports the documentation guidelines identified in the Medical Staff Rules and Regulations.
- B. The purposes of the Medical Record are:
 1. To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.
 2. To document the patient's medical evaluation, treatment and change in condition during the hospital stay or during an ambulatory care or emergency visit.
 3. To allow a determination as to what the patient's condition was at a specific time.
 4. To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment.
 5. To assist in protecting the legal interest of the patient, hospital and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.
- C. Charts will be completed according to Medical Staff Bylaws, Rules and Regulations. Records will be classified as delinquent if not completed in their entirety within seven (7) days after the patient's discharge. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient.

II. Definitions:

- A. Authentication: The term "Authentication" means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential.
- B. HIMS – Health Information Management Services
- C. EMR – Electronic Medical Record
- D. Physician/Practitioner: For the purposes of this policy, physician/practitioner includes physicians, dentists, podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform surgical procedures.
- E. Supervisory Practitioner – The supervisory practitioner is defined as a staff physician at Banner Churchill Community Hospital, as appropriate, who has oversight responsibility for all aspects of patient care rendered by students and residents.

Medical Documentation Templates

Amanda Symonds



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Medical Records Manager - The Comprehensive Guide DEAN STRATTON, Whether you run a solo clinic or a multi site practice Medical Records Manager The Comprehensive Guide turns messy charts into reliable compliant and searchable health information Inside you'll find step by step workflows for EHR data entry chart correction release of information retention schedules and audit prep plus checklists sample forms and scripts your team can use tomorrow End to end workflows from intake and identity proofing to archiving and purge with role based swimlanes Compliance made practical HIPAA PHI handling minimum necessary break glass logging downtime disaster playbooks Quality coding chart integrity tips common error patterns reconciliation logs and coding handoffs ROI toolbox request triage matrix verification scripts fees policy examples and fulfillment trackers Data governance naming conventions metadata version control and secure migration merger checklists Picture a Monday 8 a.m. a patient requests records a payer flags an inconsistency and your EHR is scheduled for an update Using this guide you triage the request in minutes reconcile the discrepancy and roll out a safe change without disrupting care Equip your team with clarity reduce denials and make records work for people not the other way around

Soap Notes Dot Phrase Templates For Medical Records Amanda Symonds, 2022-07-22 Are you responsible for entering accurate patient progress notes and feel they are often incomplete Have you considered setting up dot or smart phrases in your electronic health records EHR or need to update or expand the templates you currently have We have produced ready to use medical dot phrase templates for primary care specialties that you can adapt This also includes templates for Covid 19 Medical notes often lack important information which can lead to mistakes and treatment delays for patients It's hard enough to remember all the different things you need to do for each patient much less try to come up with the right words to document their care Don't wait for an audit to highlight your clinic's weaknesses Soap Note Dot Phrase Templates For Medical Records is a tool that makes it easy for you to enter patient notes quickly and easily With our pre made dot phrases all you have to do is select the right one and it will automatically prompt you to fill in the correct information Our book includes easy to use templates that will help you enter complete and accurate patient notes and medical documentation quickly With our pre made dot phrases you'll have everything you need at your

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learning and problem solving skills Chapter Review Activities allow you to assess your knowledge of the material with activities such as a review of key terms matching and true false questions and additional opportunities for software practice Review of Paper Based Office Procedures describes how tasks are completed when the healthcare facility is using paper based procedures instead of electronic Trends and Applications provide real life examples of how EHR systems are being used to improve health care Application exercises in the appendix include front office clinical care and coding and billing allowing you to practice skills before tackling graded SCMO exercises Student resources on the Evolve website include a custom test generator to allow CEHRS exam practice or simulation NEW Content is aligned to the latest blueprint for the Certified Electronic Health Records Specialist CEHRS exam NEW Updated coverage includes data validation and reconciliation patient portals EHR training IT troubleshooting techniques common documentation errors reimbursement systems and processes authorizations federal guidelines and escalation procedures and reporting NEW Screenshots demonstrate EHR applications within SimChart for the Medical Office

Documentation Basics Mia Erickson, Mia L. Erickson, 2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Second Edition of Documentation Basics A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever evolving profession Updated inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition The discussion on integrating disablement into documentation The discussion on how a PTA can show medical necessity and need for skilled care The discussion on using documentation to communicate with other providers Writing the assessment and plan to coincide with the initial documentation Sample notes completed on forms More examples and practice including physical agents school based services paediatrics traumatic brain injury spinal cord injury and interventions consistent with the Guide to Physical Therapist Practice Medicare reimbursement in different settings The importance of consistent reliable and valid measurements How to improve communication and consistency between documentation by the PT the PTA The discussion on disablement has also been updated shifting away from the Nagi Model toward the International Classification of Functioning Disability and Health ICF In addition the PTA Normative Model has been integrated throughout to include more information on clinical decision making New inside Documentation Basics A Guide for the Physical Therapist Assistant Second Edition Navigating the PT plan of care A step by step model for PTAs to use as they navigate the initial PT documentation and plan of care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono

services Instructors in educational settings can visit www.efacultyounge.com for additional material to be used for teaching in the classroom Documentation Basics A Guide for the Physical Therapist Assistant Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation An Ontology Model for Clinical Documentation Templates Joyce George (S.M.),Harvard University--MIT Division of Health Sciences and Technology,2005 There are various kinds of clinical documents used in a hospital or clinic setting With the emergence of Electronic Medical Records efforts are being made to computerize these documents in a structured fashion in order to enable decision support With structured data entry because each fact about the patient is stored discretely and can be retrieved separately information can be organized and presented in different ways depending on the needs of the user A typical structured clinical document contains a range of findings recorded by a physician nurse or other care These findings can be thought of as discrete pieces of information called observations These observations can be grouped together to form observation sets that can be placed under relevant headers within the document When building information systems that support structured clinical documentation these observations and sets are created and stored in catalogs My thesis addresses the issue of building an ontology model for clinical documentation that supports the creation and management of an observations catalog observation sets catalog and a clinical document catalog The ontology can be used as an organizational tool for efficient maintenance of these catalogs By tagging observations and observation sets with relevant attributes it is possible to generate intelligent displays of data that are more flexible and dynamic

Documentation for Rehabilitation- E-Book Lori Quinn,James Gordon,2009-12-18 Four NEW chapters address additional aspects of documentation that rehabilitation professionals will encounter in practice Legal aspects of documentation Documentation in pediatrics Payment policy and coding Computerized documentation *Clinical Decision Support and Beyond* Robert Greenes,Guilherme Del Fiol,2023-02-10 Clinical Decision Support and Beyond Progress and Opportunities in Knowledge Enhanced Health and Healthcare now in its third edition discusses the underpinnings of effective reliable and easy to use clinical decision support systems at the point of care as a productive way of managing the flood of data knowledge and misinformation when providing patient care Incorporating CDS into electronic health record systems has been underway for decades however its complexities costs and user resistance have lagged its potential Thus it is of utmost importance to understand the process in detail to take full advantage of its capabilities The book expands and updates the content of the previous edition and discusses topics such as integration of CDS into workflow context driven anticipation of needs for CDS new forms of CDS derived from data analytics precision medicine population health integration of personal monitoring and patient facing CDS In addition it discusses population health management public health CDS and CDS to help reduce health disparities It is a valuable resource for clinicians practitioners students and members of medical and biomedical fields who are interested to learn more about the potential of clinical decision support to improve health and

wellness and the quality of health care Presents an overview and details of the current state of the art and usefulness of clinical decision support and how to utilize these capabilities Explores the technological underpinnings for developing managing and sharing knowledge resources and deploying them as CDS or for other uses Discusses the current drivers and opportunities that are expanding the prospects for use of knowledge to enhance health and healthcare Understanding, assessing, and guiding adaptations in public health and health systems interventions: Current and future directions Roman Aydiko Ayele,Borsika Adrienn Rabin,Catherine Battaglia,Marina McCreight,2023-07-19 *Health Information - E-Book* Mervat Abdelhak,Mary Alice Hanken,2014-12-24 Uncover the latest information you need to know when entering the growing health information management job market with Health Information Management of a Strategic Resource 5th Edition Following the AHIMA standards for education for both two year HIT programs and four year HIA programs this new edition boasts dynamic state of the art coverage of health information management the deployment of information technology and the role of the HIM professional in the development of the electronic health record An easy to understand approach and expanded content on data analytics meaningful use and public health informatics content plus a handy companion website make it even easier for you to learn to manage and use healthcare data Did You Know boxes highlight interesting facts to enhance learning Self assessment quizzes test your learning and retention with answers available on the companion Evolve website Learning features include a chapter outline key words common abbreviations and learning objectives at the beginning of each chapter and references at the end Diverse examples of healthcare deliveries like long term care public health home health care and ambulatory care prepare you to work in a variety of settings Interactive student exercises on Evolve including a study guide and flash cards that can be used on smart phones Coverage of health information infrastructure and systems provides the foundational knowledge needed to effectively manage healthcare information Applied approach to Health Information Management and Health Informatics gives you problem solving opportunities to develop proficiency EXPANDED Data analytics meaningful use and public health informatics content prepares HIM professionals for new job responsibilities in order to meet today s and tomorrow s workforce needs EXPANDED Emphasis on the electronic health care record educates you in methods of data collection governance and use NEW Chapter on data access and retention provides examples of the paper health record and its transition to the EHR NEW Focus on future trends including specialty certifications offered by the AHIMA the American Medical Informatics Associations AMIA and the Health Information Management Systems Society HIMSS explains the vast number of job opportunities and expanded career path awaiting you **Effective Documentation for Physical Therapy Professionals** Eric Shamus,Debra Feingold Stern,2004 This is a comprehensive textbook for the documentation course required in all Physical Therapy programs The textbook incorporates current APTA terminology and covers every aspect of documentation including reimbursement and billing coding legal issues PT and PTA communication as well as utilization review and quality assurance Midwest Imaging &

Document Solutions ,2000 **Health Information** Mervat Abdelhak,2007 Gives prospective health information management professionals the knowledge confidence and practical application experience to succeed in health informatics

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Communicating Clinical Decision-Making Through Documentation: Coding, Payment, and Patient Categorization Eric Shamus,Debra F. Stern,William F. McGehee,2021-02-01 Publisher s Note Products purchased from Third Party sellers are not guaranteed by the publisher for quality authenticity or access to any online entitlements included with the product Clear concise and simple to follow everything you need to master the documentation process quickly and easily Communicating Clinical Decision Making Through Documentation is the top choice for professionals and students seeking complete coverage of the documentation process including billing and coding It shows how to ensure every service rendered and billed is supported by showing what to document how to do it and why it is so important This text includes a refreshing student friendly approach to the topic You will find an abundance of cases portraying real life case scenarios and it delivers must know information on writing patient client care notes incorporating document guidelines documenting clinical decision making includes evidence based practice and performing billing and coding tasks With Communicating Clinical Decision Making Through Documentation you ll effectively maintain and organize records record appropriate information and receive proper payment based on the documentation content A to Z coverage of physical therapy documentation including Documentation Standards and Guidelines Medicare Home Health Electronic Medical Records EMR International Classification of Functioning ICF Model and Application Pediatrics Legal Issue Utilization Review Management Skilled Nursing Facilities Sample Documentation Content Initial Examination and Evaluation Criteria Continuum of Care Content and Goal Writing Exercises Documentation Aspects of Supervising PTAs Abbreviations Payment ICD 10 and CPT Codes and Application Chapter Review Questions Content Principles *Diabetes Care Documentation and Coding* Jerome S. Fischer,2002 **Im,Format/Doc Process Essent** FORDE,WOO,VANHUSS,2004-05

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