

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

James E. Vance



Medical Documentation Templates:

StatNote Gerardo Guerra Bonilla MD, 2019-07-31 As a primary care physician you know that completing clinic notes while you're treating many patients is time consuming and challenging That's why StatNote a library of more than 1 000 medical templates was created for you It reduces busy work and enables you to focus on the most important part of the office visit your patient StatNote's dot phrases help you Efficiently document office visits and common procedures Write patient messages in English and Spanish to communicate lab and imaging results Easily retrieve common evaluation and management E M and current procedural terminology CPT codes used for billing This book familiarizes you with all the available boilerplate templates An electronic version can be purchased at statnote.com and used with a text expander in any Electronic Health Record EHR system 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 fingertips This book includes information about how to use and edit dot phrases in medical records for any EHR for example we include templates for Medical History Current Medications Assessment Allergies Vitals Physical Exam Procedures Plans Calls Decision Making COVID 19 particulars If you need to be more efficient in your medical records administration or are simply searching for new dot comment ideas and phrases for your EHR system then this ready to use medical dot phrase template book is right for you 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

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The Electronic Health Record for the Physician's Office E-Book Julie Pepper, 2023-07-19 Get realistic hands on practice with performing EHR tasks Combining a print textbook with online SimChart for the Medical Office software The Electronic Health Record for the Physician's Office 4th Edition uses real world examples and screenshots to walk you through each EHR task Clear step by step guidelines simplify the exercises in each simulation so you master all the EHR skills required of a medical office professional You ll learn how to use EHR in patient care and reimbursement as you perform tasks in administrative use clinical care and coding and billing Written by Medical Assisting educator Julie Pepper this manual also helps you prepare for success on the Certified Electronic Health Records Specialist CEHRS examination UNIQUE Integration with SimChart for the Medical Office SCMO Elsevier's educational EHR sold separately makes it easier to learn and apply EHR fundamentals EHR Exercises with step by step instructions reinforce key concepts and allow practice with actual software increasing in difficulty based on the knowledge gained Critical Thinking Exercises provide thought provoking questions to enhance 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

The Complete Medical Scribe, E-Book ABC Scribes, LTD, 2021-11-16 Expand your career opportunities with this concise all in one guide to a dynamic and growing healthcare career The Complete Medical Scribe A Guide to Accurate Documentation 3rd Edition provides the information you need to document patient health records accurately thoroughly and efficiently Coverage includes activities such as creating a note recording a patient history and review of systems documenting diagnostic tests and therapeutic procedures and noting follow ups for labs or imaging A strong foundational knowledge of anatomy and body

systems is emphasized Written by two medical doctors in conjunction with the experts at ABC Scribes this comprehensive resource will prepare you to become an essential member of the healthcare team in a variety of settings Comprehensive coverage includes everything you need to know to work as a medical scribe including medical law and ethics safety and infection control health record documentation billing and reimbursement requirements medical terminology basics and detailed body system coverage Clinical scenarios represent common situations and promote real world application of the scribe s function Case studies with questions test your comprehension and let you apply your knowledge to the clinical setting Review questions and exercises within chapters and online provide opportunities for self quizzing to identify areas of strength and areas of focus Nearly 200 colorful medical illustrations and photos depict subjects such as anatomy and physiology as well as online charting within the electronic health record EHR Detailed instructional videos online simulate medical practice using real doctor patient encounters that progress logically through each part of the EHR Notes boxes emphasize practice dos and don ts along with on the job realities

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 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

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

health informatics *Transforming Health Care Through Informatics* Nancy M. Lorenzi,1999 **Pharmacotherapy Casebook** Terry L. Schwinghammer,Julia M. Koehler,2008-08-29 50% all new cases in this edition 50% of cases revised Over 140 cases total Organization by organ systems to coordinate with the textbook Cases range from simple a single disease state to complex multiple disease states and drug related problems Develops skills in problem analysis and decision making Integrates the biomedical and pharmaceutical sciences with therapeutics Demonstrates the relevance and importance of a sound scientific foundation for pharmacy practice *The Physician Compliance Auditing and Monitoring Manual* Bill Dacey,2001 **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 **Pharmacotherapy Casebook: A Patient-Focused Approach, Eighth Edition** Terry Schwinghammer,Julia Koehler,2011-06-17 More than 150 cases help you develop the problem solving and decision making skills necessary to succeed in real world clinical practice Pharmacotherapy Casebook provides the case studies you need to learn how to identify and resolve drug therapy problems you re most likely to encounter in real world practice This new edition is packed with 157 patient cases and makes the ideal study companion to the eighth edition of DiPiro s Pharmacotherapy A Pathophysiologic Approach The case chapters in this book are organized into organ system sections that correspond to those of the DiPiro textbook By reading the relevant chapters in Pharmacotherapy A Pathophysiologic Approach you will be able to familiarize yourself with the pathophysiology and

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