EXERCISE 4–1 Definition and Purpose of the Patient Record

Matching: Enter an "A" if the item is administrative data and a "C" if it is clinical data.

_____ 1. Laboratory report
_____ 2. Patient name
_____ 3. Patient's insurer
_____ 4. Vital signs
_____ 5. Progress note
_____ 6. Patient number
_____ 7. Hospital name and address
_____ 8. Problem list
_____ 9. Attending or primary care physician
_____ 10. Care plan
_____ 11. Allergies
_____ 12. Medications
_____ 13. Date of birth
_____ 14. Occupation
_____ 15. Anesthesia record

PROVIDER RESPONSIBILITIES

The Joint Commission standard RC.01.02.01 states that "only authorized individuals may make entries in the medical record." AHIMA recommends that "anyone documenting in the health record should be credentialed or have the authority and right to document as defined by the organization's policy. Individuals must be trained and competent in the fundamental documentation practices of the organization and legal documentation standards. All writers should be trained in and follow their organization's standards and policies for documentation."

Health care providers are responsible for documenting care, treatment, and services rendered to patients in a manner that complies with federal and state regulations as well as accreditation, professional practice, and legal standards. It is important to remember that services rendered *must* be documented to prove that care was provided and that good medical care is supported by patient record documentation. Thus, inadequate patient record documentation may indicate poor health care delivery; if services provided are not documented, continuity of care is compromised.

Note: Providers must remember the familiar phrase, "If it wasn't documented, it wasn't done." Because the patient record serves as a medicolegal document and the facility's business record, if a provider performs a service but doesn't document it the patient (or third-party payer) can refuse to pay for the service. In addition, because the patient record serves as an excellent defense of the quality of care administered to a patient, missing documentation can result in problems if the record needs to be admitted as evidence in a court of law.

> ***Example*** A third-party payer routinely reviews inpatient claims to ensure that all services billed are documented in patient records. If reconciliation of the claim with the patient record results in the determination that documentation is missing, the payer can reduce payment of the amount billed on the claim. Sunny Valley Hospital submitted a claim that reported radiology and laboratory services for Pamela Wright. The total charges were $3,400, including a $120 charge for a cholesterol screening. The payer reviewed copies of patient records, determined that cholesterol screening documentation was missing, and disallowed the charge due to an unsubstantiated charge.

Authentication of Patient Record Entries

All patient record entries require **authentication**, which means an entry is signed by the author (e.g., provider). The *Federal Regulations/Interpretive Guidelines for Hospitals (482.24(c)(1)(i))*, published by the Centers for Medicare & Medicaid Services, specifies that only the *author* of an entry can authenticate that entry, thus establishing that the entry is accurate and has been verified by the author. Guidelines further state that "failure to disapprove an entry within a specific time period is *not* acceptable as authentication." The *Guidelines* also allow for authentication of patient record entries through an author-entered computer code.

Note: **Auto-authentication** involves a provider authenticating a dictated report prior to its transcription. This practice is not consistent with proper authentication procedures because providers must authenticate the document *after* it was transcribed. Each health care facility must select acceptable authentication method(s), which comply with federal, state, and/or third-party payer requirements. Methods include:

- Written signatures
- Countersignatures
- Initials
- Fax signatures
- Electronic signatures or computer key signatures
- Signature stamps

The Joint Commission standard RC.01.02.0 states that entries in the medical record are to