oscar

CLINICAL DOCUMENTATION

Encounter Requirements

Complete and compliant documentation can serve to improve quality and continuity of care, enhance communication of the patient's health and care needs, and increase patient safety. Added benefits for providers and organizations can include improved decision making, consistent data, enhanced accuracy, increased revenue and legal protections.

REQUIRED DOCUMENTATION DETAILS:

- **Date of service**
- **Two patient identifiers on every page**
- **Industry standard abbreviations only**
- **Provider signature and credentials**

PATIENT IDENTIFIERS:

- **Name**: First and last name are required.
- **Date of Birth**: This is a crucial identifier to ensure accurate patient matching.
- **Medical Record Number**: A unique alphanumeric identifier assigned by the facility.
- **Other Identifiers**: Social Security number (SSN) or other person-specific identifiers may also be used.

Importance of using two identifiers:

Reduced Risk of Error: Using at least two patient identifiers minimizes the risk of reviewing or documenting for an incorrect patient.

Enhanced Patient Safety: Accurate patient identification is key for patient safety, as this can prevent errors in treatment and management.

SIGNATURE REQUIREMENTS:

Legibility: Signatures must be legible and completed by the performing provider:

Credentials: Signatures should include the provider's credentials (e.g., MD, NP).

Timeliness: Signatures must be compliant and completed within a timely manner. “Late signatures may not be added to the record, beyond the short delay that occurs during the transcription process.” Medicare Program Integrity Manual (Pub 100-08)

Acceptable Handwritten Signatures:

Legible full signature

Legible first initial and last name

Initials over a typed or printed name

Illegible signature over a typed or printed name

Illegible signature where the letterhead or other information indicates the identity of the signator

Acceptable Electronic Signatures:

"Electronically signed by"

"Authenticated by"

"Approved by"

"Completed by"

"Finalized by"

"Validated by"

DIAGNOSES TO INCLUDE:

Pertinent Conditions

- Chief complaint that necessitated the encounter
- Present but controlled
- Managed on therapy
- Requires monitoring
- Prompts referral to another provider
- Influences your decision making in care of the patient

Chronic Conditions

- Document chronic conditions annually, even when controlled with treatment
- Document severity/stage of condition including the acuity status
- Document associated conditions or complications and relationship to the underlying chronic condition

Status codes

- Substance-related disorders in remission
- Ostomies (that have not been reversed)
- Amputation
- Transplants
- Alcoholism in remission
- Mental health in remission
- Paraplegia/Quadriplegia
- Personal history of health events
  - History of stroke without sequelae
  - History of MI