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Medical record documentation

Deadline: Postmarked no later than **September 1, 2018**
Credit: 2 AAMA CEUs (gen/adm) **Code: 134002**

Directions: Determine the correct answer to each of the following, based on information derived from the article.

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☐ ☐ 1. Medical records can be used to evaluate the quality of care provided by health care practitioners.

☐ ☐ 2. During a medication review, an end date should be entered into the electronic health record when a prescription has been discontinued.

☐ ☐ 3. State law specifies the legal requirements for medical records documentation in detail.

☐ ☐ 4. Most audits result in deletion of diagnosis codes and recoupment of payment previously received by a provider.

☐ ☐ 5. The name or initials of the health care providers who treated the patient at specific points in time should not be included because of Health Insurance Portability and Accountability Act (HIPAA) considerations, according to the National Committee for Quality Assurance (NCQA) "Guidelines for Medical Record Documentation."

☐ ☐ 6. A medical record in conformity with NCQA guidelines should include a statement that the treatment recommended by the provider did not create inappropriate risks for the patient.

☐ ☐ 7. The review of systems (ROS) should be relevant to the patient's chief complaint (CC) and should not include body systems unrelated to the patient's CC.

☐ ☐ 8. Information entered into the medical record by the provider's staff should be reviewed, approved, and signed by the provider.

☐ ☐ 9. Although staff may enter a large amount of information into the medical record, the overseeing provider must enter the CC and history intake.

☐ ☐ 10. Conducting periodic chart reviews is a way of checking whether all the documentation practices are adequate.

☐ ☐ 11. Each patient's medical record should include health history and treatment received in chronological order.

☐ ☐ 12. The health care provider should discuss the medical history and CC with each patient to make sure that there have been no changes in the medication prescribed by other providers.

☐ ☐ 13. To not alarm a third-party payer, only the main diagnosis should be coded, not the other diagnoses.

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☐ ☐ 14. Generally, the greater the number and severity of health problems of a patient, and the greater the amount of care provided, the higher the coding levels.

☐ ☐ 15. If a patient has been referred to a provider, and that provider reviews test results and office notes from the referring provider, the information from the referring provider should be reviewed and included in the notes of the second provider.

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