EVMS MEDICAL GROUP		
POLICY: Medical Documentation Requirements	**DATE: 07-31-1996**	
CATEGORY: COMPLIANCE	**REVIEWED/ REVISED: April-13**	**Page 1 of 1**

POLICY: All services rendered by a provider at any level are to be completely and accurately documented in the patient's permanent medical record.

PROCEDURE: The provider will document a personal note for each patient encounter. This note will contain the provider's statement of services, summary of findings, and document his/her presence during the key portion of the encounter or procedure performed by the resident.

STANDARDS:

- Single institutional policy for documentation, regardless of payer.
- Policy applies to all providers in all settings at all times.
- All residents must be supervised by the teaching physician, with appropriate documentation, as specified in the CMS Teaching Physician Guidelines found in the Medicare Claims Processing Manual, Chapter 12, Section 100.

http://www.cms.gov/manuals/downloads/clm104c12.pdf

GOALS:

- Accurate documentation of services rendered.
- Documentation of faculty involvement.
- To maintain and document quality of care.
- To comply with external requirements (National Committee for Quality Assurance--NCQA, hospitals, carriers).
- To facilitate reimbursement.