Basic Principles of Medical Documentation

LEARNING OBJECTIVES

Following the completion of this chapter, the reader will be able to:

1. Identify and explain the principles of medical documentation.

2. Describe the documentation standard set forth by the Board of Certification Standards of Professional Practice.

3. Describe the proper method for an athletic training student to sign a medical record.

Standards and guidelines for medical documentation have been established by a variety of organizations, including the Centers for Medicare & Medicaid Services (CMS). The largest third-party payer in the United States, CMS, sets standards and guidelines for medical documentation for participating health care providers, such as physicians and hospitals. Health care professions such as, nursing and physical therapy, also establish standards and guidelines for documentation. The significance of the CMS requirements is that they are regarded as the gold standard and are often adapted for use by other third-party payers (insurance companies). So, if an athletic trainer seeks reimbursement for services, regardless of the insurance carrier providing the payment, the CMS standards and guidelines may indirectly or directly apply. Aside from reimbursement being the reason for documentation standards, athletic trainers must be cognizant of industry standards and expectations with all other related documentation. To date, specific guidelines for best practice for all athletic training settings only exist as they relate to specific functions (eg, emergency action plans, reimbursement, history forms). Documentation for the athletic trainer is addressed in the Board of Certification (BOC) Standards of Professional Practice as described in the previous chapter.

Since documents such as the BOC Standards of Professional Practice are used to establish the standard of care for athletic trainers at this time, the athletic trainer is obligated to adhere to its guidelines (Appendix A).

While documentation standards and guidelines vary among health care settings, certain principles are commonly held as essential to all types of medical documentation because the medical record is a legal document. These rules are derived from the various documentation standards and guidelines in health care, as well as legal statutes.

Pearl of Wisdom

Practice, practice, practice. Proficiency in medical documentation requires continual critiquing and refining.

MEDICAL TERMINOLOGY

All health care providers should use appropriate medical terminology in medical documentation. The use of appropriate medical terminology serves to enhance communication among and between all types of health care providers. Types of medical terminology with which the athletic trainer, and all health care professionals, must be familiar include terms associated with pathology, biomechanics, orthopedics, general medicine, and the musculoskeletal system. For example, body parts should be described using anatomical nomenclature (eg, “tibia” instead of “lower leg,” “patella” instead of “knee cap,” and “scapula” instead of “shoulder blade”). Movement should be described using correct biomechanical terms (eg, “gait” instead of “walk”). The use of appropriate and professionally accepted terminology gives the athletic trainer a level of distinction and respect as a health care provider, separate from the