Medical Documentation

The Purpose and Significance of Medical Documentation

A patient record, also known as a medical record, is a legal document that is intended to support continuity of care. It serves as a communication tool for all healthcare professionals serving that patient.

The patient record includes the following:

- Demographic information
- Illnesses
- Treatment
- Diagnoses
- Services
- Procedures
- Care plan

In addition, patient records also do the following:

- Aid in evaluating the quality of patient care
- Maintain data for:
  - Clinical research
  - Epidemiological tracking
  - Training and education
  - Risk management
  - Policy
  - Facilities planning
Other healthcare statistical analysis
Serve as the medico-legal official documentation
Provide claim information for reimbursement of services
Serve as the basis for coding

If the diagnosis does not match the services and procedure, an insurance company will deny reimbursement. This process is referred to as **medical necessity**.

**Documentation for Medical Necessity**

Medical necessity requires documentation for determining services and supplies for the following:

- Diagnosing and treating a medical condition
- Providing direct care services for a medical condition
- Complying with good medical practice standards
- Providing services which are not primarily for the ease of the healthcare provider