

WYOMING WORKERS' COMPENSATION

STANDARDS FOR CONTENT OF MEDICAL RECORDS

Entry/documentation for each health care provider visit

- Medical notes must be legible. Type written/computer generated preferred.
- Date of patient visit.
- Reason for encounter/Chief Complaint. The reason for the visit should be described using the patient's own words.
- History and Physical Exam *focused* relative to complaint. There should be a description of the findings of the exam. The exam and findings should relate to the reason for encounter/chief complaint.
- Diagnosis consistent with presenting complaint, including side and body part.
- Plan of action consistent with diagnosis.
- Pertinent orders. The studies ordered should pertain to the issue being addressed.
- Education/Instruction to the patient.
- Follow-up. There should be some indication of when the physician would like to see/hear from the patient again for the purposes of follow-up care. A physician may indicate follow-up on a "PRN" basis.
- Authenticated.

- The case analyst:
1. May not pay the office visit if the documentation standards are not met;
 2. Contact the health care provider to resubmit the not clarifying the medical documentation.