POLICY 12
The Effect of the Medical Review Process on the Clinical Practice of Medicine

The purpose of the medical review process is to impact medical decision-making. The goal of this process in medical quality management is to affect appropriately and positively the process and outcome of patient care. Since the medical review process does influence the clinical care patients receive, the review process itself must ensure that it affects appropriately providers’ performance producing medical decision-making consistent with the applicable standard of care.

Health care review professionals involved in the review process are practicing medicine and therefore they must be credentialed and qualified and must adhere to the standard of care as applied to medical decision-making.

References:
Igelhart, J.K: Prioritizing Comparative-Effectiveness Research—IOM Recommendations. NEJM 2009;361(14), 325-327
Principles of Medical Ethics; AMA House of Delegates June 17, 2001
ACMQ Professional Policy #3, Standards of Care

Adopted by the Executive Committee, 12/5/92
Amendments adopted by the Board of Trustees, 11/13/97, 2/21/04, 2/17/10

POLICY 13
Documentation

Documentation is the recording of information by organizations and individuals involved in providing clinical health care services or performing health care review. It is the most reliable indicator of the care that has been provided or of the review that has been performed.

Documentation is essential to the continuous quality improvement (CQI) process, ensures communication among medical personnel and is critical to the assessment, planning, implementation, continuity and evaluation of quality medical care.

Appropriate documentation must be legible, timely accurate, contain all significant and pertinent data, be date specific and where appropriate time specific. All entries to the health care record must be authenticated by the person generating the documentation. It must support the medical necessity and level of care for all services or supplies provided at a specific time.

Documentation must reflect the analytical assessment process involved in medical decision-making.

Decisions by third party payors should be based on documentation from the medical record. After-the-face oral or written recollections of the provision of care or the performance of review activities are not substitutes for timely and appropriate documentation.

The failure to document appropriately is inconsistent with professionally acceptable standards of medical care and review.

References:

Adopted by the Board of Trustees, 3/27/96
Amendments adopted by the Board of Trustees, 2/21/04, 2/17/10