MR.8 **The hospital uses nationally recognized standardized diagnosis and procedure codes.**

MR.8.1 The hospital uses the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) for diagnosis coding.

MR.8.2 The hospital uses Australian Classification of Health Interventions (ACHI) for procedure coding.

MR.9 **There is a process to ensure availability of the medical records in a timely manner.**

MR.9.1 The hospital determines in a policy all disciplines who may have access to the medical records.

MR.9.2 Care providers have access to current and past medical records.

MR.9.3 Medical records are readily retrievable for each patient encounter.

MR.9.4 Medical records are available within thirty minutes of being requested.

MR.9.5 Medical records can be retrieved any time of the day.

MR.10 **Medical records are consistently organized.**

MR.10.1 Individual medical records are securely compiled.

MR.10.2 Medical records are organized into sections. (e.g., a section for test results, operative reports, consultations, discharge summary).

MR.10.3 The different sections of the medical record are organized chronologically (e.g., the physician orders start with the initial set written when the patient was admitted to the hospital and end with the discharge order).

MR.10.4 During each hospitalization episode, both in-patient and outpatient medical records are separated into different sections in the patients' medical record (e.g., for doctors' orders, nursing notes, progress notes).

MR.11 **The hospital has a system to manage voluminous medical records.**

MR.11.1 There is a system that enables medical record linkage.

MR.11.2 When the medical record is divided into volumes, the number of each volume should be clearly visible on the folder and on the sign-out slip (e.g., "Volume 1 of 2", "Volume 2 of 2,").

MR.11.3 When the hospital practices thinning of voluminous medical records:

MR.11.3.1 The hospital develops thinning guidelines that remain consistent for the type of documentation contained.

MR.11.3.2 The hospital retains documentation in the medical record that reflects the current plan of care and services provided.

MR.11.3.3 The hospital removes parts of the medical record older than a certain date and moves them into a secondary record (the overflow record).

MR.12 **The hospital has a system for the retention of medical records in accordance with laws and regulations.**

MR.12.1 The hospital has a policy on the retention of medical records.

MR.12.2 The policy is consistent with laws and regulations.