USF HEALTH

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Approval: AVP for Quality, Safety and Risk, USF Health 7/18/16 | Section: Billing Integrity Documentation, Coding and Billing of Healthcare Services
Chief Operating Officer, USF Health 7/12/16 | Subject: Overview of Documentation

PURPOSE:
To establish standards for documentation of healthcare services to ensure such is supportive of accurate billing.

These Standards and Procedures are determined by Medicare, Florida Medicaid, Joint Commission on Accreditation of Healthcare Organizations, American Medical Association, Florida Administrative Code; Florida and Federal Rules of Evidence, the American Health Information Management Association, and USF Health Standards and Procedures.

An analysis and summary of laws and regulations related to medical record notes timing and signing is available at the Professional Integrity Office website under the Billing Integrity Standards & Processes tab.

DOCUMENTATION

IMPORTANCE OF DOCUMENTATION
Medical record documentation is required to record pertinent facts, findings and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments, and outcomes. In addition, the medical record documentation serves as evidence of the provision of services, who provided the care, the medical necessity, and the quality of care. The original medical documentation must be filed in the patient’s medical record at that facility/institution. The medical record is a chronological reflection of the care of the patient and is an important element contributing to the quality of care. The medical record:

- Facilitates the ability to evaluate, plan immediate treatment, and to assess health over time;
- Provides information to be used by other physicians, consultants, and other health team members in the care of the patient;
- Facilitates communication of services, service provider, and the continuity of care;
- Facilitates appropriate utilization review and quality of care evaluations;
- Serves as legal documentation for risk management and medical malpractice cases;
Establishes the basis for professional fee billing;
Facilitates accurate and timely claims review and justification; and
Provides a data source for research and education.

WHO MUST DOCUMENT
USF Physicians and Other Healthcare Professionals, collectively “USF Providers”, have responsibility for understanding documentation requirements because of their direct involvement in patient care and their ultimate responsibility for billing associated professional fees. USF Providers are responsible for appropriately documenting the services provided to their patients. In all cases, whether billable or not, the USF Provider must clearly document his/her presence and level of participation in the service provided as described in the medical records. This may be done either by personally writing, typing, dictating to a transcriptionist or transcription service, or entering information into an electronic health record (EHR).

A transcriptionist may transcribe, by hand (scribe) or by typing, medical record notations personally dictated by the USF Physician. Refer to the USF Health Standard Practices and Procedures 05.03a "Use of Scribes".

MAINTAINING THE INTEGRITY OF MEDICAL RECORD ENTRIES
In order to preserve the integrity of medical records, it is imperative to keep dictation and electronic medical record access numbers secure. Allowing anyone else to know one’s access number or use one’s number or login session to make medical record entries calls into question the integrity of all entries made under that access number. Therefore, such activities are strictly prohibited and as identified, will result in corrective/disciplinary action.

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION (based on guidelines established jointly by CMS and AMA)
These principles apply to all types of medical and surgical services in all settings:

1. The medical record should be complete and legible. It is important to note that illegible documentation may be considered invisible or absent, and lack of documentation may be interpreted as no service was performed.

2. Documentation for each patient encounter should include:
   - the reason for the encounter and relevant history;
   - physical examination findings;
   - diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care;
• date and legible identity of the care provider(s); and
• signature and identification of the provider(s).

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.

Documentation must clearly support each CPT and each ICD-10-CM code reported on the patient encounter form (charge ticket) and resulting health insurance claim forms or billing statements. If supporting documentation is located in various parts of the medical record, a reference to each supporting document by date or name of form must be made. For example, when documenting an E/M service, a patient-completed history form may be incorporated when the progress note refers to the review of the history form (i.e. "reviewed Questionnaire from today’s visit with patient").

TEMPLATES and MACROS
Documentation templates may be used to assist in capturing medical documentation. Templates may be in paper or electronic format. The Professional Integrity Office is available to assist in the development of such tools (974-2222).

USF Health is committed to quality patient care and to the integrity of medical records. To ensure appropriate implementation of such, any documentation template, macro, aid, or tool used by USF Providers, whether paper or electronic, must be developed within established USF Health Billing Integrity guidelines as on file at the Professional Integrity Office. Any requests that fall outside of these guidelines are submitted for review by the Professional Integrity Office and, as warranted, routed for review/input by the Billing Integrity Advisory Committee and approval. This includes implementation of “default” or “pre-populated” data as well as any “text inserts” or “macros” in the USF electronic medical record and to any such tools intended for use at affiliated sites of service, such as Moffitt, Tampa General Healthcare, All Children’s Hospital, and University Community Hospital. Recognizing that electronic efficiencies may pose a risk of inaccurate, inadequate or non-specific documentation, USF Providers using such are expected to carefully review and edit notes prior to finalizing.

In the context of an electronic medical record, the term “macro” means a command in a computer or dictation system that automatically generates
predetermined text that the system does not prompt for editing by the user. The term “text insert” or “text template” means a template with predetermined text wherein the system prompts for additional information that is edited by the user.

When used mindfully, macros and templates can add efficiencies to the documentation process. Without due attention, their use may result in finalized notes that describe services in excess of what was actually provided at a particular visit or that do not include information specific to the patient, and can result in “upcoding” or other erroneous billing. Whether a note is handwritten, dictated or created using macros or text inserts, it is vital that the medical record contain individualized documentation of the medically necessary service (procedure performed and/or patient care provided) for each date of service.

Of special note, CMS allows use of macros in meeting the teaching physician note requirements, but only when carefully managed. The Centers for Medicare and Medicaid (CMS) clarified in January 2006 that “it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician’s macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.”

“Defaulted”, “carry forward” or “pre-populated” documentation is documentation recorded elsewhere, sometimes by other individuals and on other dates, such as an “active problems list” or “PFSH”. This data also can facilitate completion of notes when used mindfully; or result in erroneous documentation and billing when used inattentively. Again, when using such tools, USF Providers must be careful to avoid creating documentation that describes services other than what was actually provided at the particular visit. To ensure accuracy of the final documentation, use of such tools requires active steps by the provider in reviewing and editing to ensure inclusion only of data pertinent to the visit. These active steps can include cutting, pasting, editing and signing the text.

“Cloned” documentation is a term used to describe entries in the medical records that are identical or unreasonably similar when comparing either visit to visit or patient to patient notes. For example, documentation of all patients with a particular diagnosis is essentially identical, implying that all patients require the exact same treatment. Cloning is considered a misrepresentation of medical necessity, and may be considered fraudulent, as these notes lack individual information for the patient encounter.
TIMELINESS OF DOCUMENTATION
Medical record documentation supportive of billing should generally be made immediately following services and be finalized with all signatures and supervisory notes on, or within 24 hours of, the date of service. Documentation identified as generated (written, dictated or entered into an EHR) by USF Providers later than within 2 days of the date of service may result in corrective/disciplinary action.

Given that more than one individual may participate in a patient’s care, it is essential that each provider ensure the timeliness of his/her own notes. Within the USF Health EHR, the Resident’s note would be completed at the visit and immediately available for the Teaching Physician’s review, attestation and signature.

In the case of inpatient services, all supervisory notes must be completed within one calendar day of the date of service as the trainee note. This accommodates situations such as late night inpatient service documentation by a Resident with a Teaching Physician note appended the following morning; and ensures a complete record is available to other treating providers.

Regardless of the documentation medium (handwritten, dictated, or electronic), the note is not considered complete until all notes, including supervisory notes, are finalized/signed.

AUTHENTICATION OF DOCUMENTATION
Authentication is the process of signing notes to verify that an entry is "complete", accurate, and final. Complete is defined as all services performed and all final diagnoses are recorded. It is the responsibility of the author of any note, report, or other medical record entry to authenticate (sign) that note, report, or entry by written or electronic signature. It is recommended that, at a minimum, the signature consists of the author’s first initial, last name, and credentials. When multiple providers are involved in the care of the patient, each provider (including Residents, Students, and Staff) should authenticate his/her own entry.

The author’s authentication must be legible in order to consider the documentation supportive of billing. If a signature is not legible, the author’s name should be printed under his/her signature.

The author should review online documentation before signing it electronically. Only the author whose name is being affixed to the documentation should electronically sign the documentation. In other words, a Resident, transcriptionist, or other person may not electronically sign a document for a Faculty physician.
ADDENDA/CORRECTION TO THE DOCUMENTATION
An addendum is additional information or clarification of clinical findings or services provided that is added to a note after it has been signed and dated. An addendum is commonly referred to as a "late entry". No addenda shall be made in the medical record solely for the purpose of meeting billing requirements. An addendum must include the omitted information, an explanation for the omission, and be signed and dated.

In no instance should past documentation be erased, marked out so that it is illegible or otherwise removed.

Any correction of erroneous information made to a note after it is signed and dated is done as follows:

With handwritten documentation, corrections are made by:
1. Drawing a single line through the mistake;
2. Writing an explanatory statement, such as "error", near it;
3. Recording the correct information; and
4. Signing and dating the correction.

With electronic health records (EHRs):
Please contact the USF Health IS Instructional Design & Training Department at 813-396-9587 for information regarding making corrections or otherwise using Epic or other USF EHRs. For assistance with EHRs at USF Affiliates, contact the respective Health Information Management office for guidance on making corrections.

KEYWORD REFERENCES:
Documentation
Medical Record
Template
Macro
Cloned
Timeliness
Authentication
Addendum

ATTACHMENT:
USFH PIO Summary of Laws & Regulations related to Medical Record Notes
Timing and Signing 7/18/16

DISTRIBUTION:
Professional Integrity Office website http://health.usf.edu/pio

STANDARD OWNER:
USF Health Professional Integrity Office
Any questions regarding this SPP should be directed as such by calling (813) 974-2222

LAST REVIEWED/UPDATED BY:
Patricia J. Bickel, CPO 4/8/16
Billing Integrity Advisory Committee 4/11/16

History of Review/Updates:
USF HEALTH Standards of Conduct & Policies
Section 5 - Documentation, Coding, and Billing of Healthcare Services - Revised April 2000;
Revised June 2007:
11/17/08 BIC approved Update:
Added description of regulatory requirements and best practices guidelines regarding timeliness of documentation. As this did not result in a policy change, EMC approval not required.
10/7/09 Update:
Added additional regulatory requirements information regarding timeliness of documentation; and updated for use of “Standards” vs. “Policy”.
9/16/10 Update:
Minor wording changes:
• Added EMR as option for documentation, Page 1
• Removed “time” from documentation requirement, Page 2
• Updated example for referencing patient-completed questionnaire, Page 3
• Added “i.e.,” to indicate that inpatient services are one instance of hand-written notes, Page 5
• Added language re: making corrections in an EMR, including Allscripts, Page 6.
As the above 2010 changes did not result in a policy change, EMC approval not required.
Jan 2015 Update:
Converted to standard USF Health SPP format and updated sections on Templates and Macros and on Timeliness of Documentation
Sep 2015 Update:
Updated the approving parties and removed references to Allscripts. Changed electronic medical record (EMR) to electronic health record (EHR).
Apr 2016 Update:
Updated the Timeliness of Documentation section to reflect expectation of complete, fully signed notes on, or within 24 hours of, the service. Removed regulatory references from within the SPP and included as an attachment.