SECTION: **COMPLIANCE**	**Approved 5/19/05**	**Effective Date 5/19/05**	**Revised**
Chapter: **MEDICAL RECORDS**	**Retired:**		
Policy: **DOCUMENTATION STANDARDS**	PAGE 1 OF 4		

I. PURPOSE

To ensure proper documentation of health care services and items provided to patients of Creighton Medical Associates (CMA) by Creighton University physicians, residents and non-physician providers. Proper medical record documentation not only supports high quality patient care (e.g., treatment, continuity of care), but also assists in accurate and timely claims review and payment and may be used a legal document to verify health care item and services provided. This purpose of this policy is to ensure proper documentation to support billing of health care services.

II. POLICY

A complete and legible medical record shall be maintained for each individual who is evaluated by and/or receives clinical treatment from a Creighton provider. All health care services and items shall be properly documented in the patient's medical record and all entries shall be signed or initialed by the provider.

III. SCOPE

This policy applies to all Creighton University employees, faculty, residents, students and agents working on behalf of CMA who make entries in CMA patient records. Entries in a patient's medical record at an institutional setting (e.g., hospital, skilled nursing facility) may be subject to additional standards established by the institution.

IV. PROCEDURES

A. The Patient Record

In addition to the general standards outlined below, documentation should meet the standards outlined by the American Medical Association and Center for Medicare and Medicaid Services (CMS) set forth on page 3 of their 1995 and 1997 Documentation Guidelines for Evaluation and Management Services as well as other institutional, governmental or private payer requirements.

1. Entries: These general standards apply to all entries in the patient's CMA medical record.

    - Each page of the patient's outpatient record shall contain the patient's name, the licensed health care provider's name, the patient's individual identifier, and the date of service.

- Only authorized individuals shall make entries in the patient's medical record. Any authorized individual who obtains clinical information (e.g., patient history, telephone calls, prescription refill calls) or provides clinical care shall document the encounter in the patient's medical record.

- All entries in the patient's medical record shall be complete and legible.

- Except as otherwise allowed under Medicare's Teaching Physician rules, entries shall be made by the person providing the health care service or item. "Scribes" shall not be used to document a provider's personally performed services.

- Handwritten entries shall be made in black or blue ink pen.

- All entries into the patient's record should be legibly signed or initialed by the person making the entry, and shall include the person's credentials (e.g. M.D., D.O., H.O., ARNP, PA, M-4, RN). Electronic signatures may be used, provided they are consistent with federal and state laws.

- Health care services or items should be documented as soon as practicable after the service or item is provided.

- If clinical information is dictated, then only the person who provided the clinical service shall dictate the information. In those instances where a resident dictates the patient encounter in a clinic setting, which is then signed by the teaching physician, the resident's initials shall be indicated (not signed) somewhere on the dictated report.

- Abbreviations used in the patient's record shall be from a list of abbreviations approved by the Department or Creighton University Medical Center (CUMC) Hospital.

- Telephone or verbal conversations concerning a patient's clinical care or medical advice shall be promptly documented and filed in the patient's medical record, and shall include the date and time of the conversation.

- Telephone orders must be added to the record within a reasonable time and authenticated (e.g., signature or initial) by the ordering provider.

2. Billing for Health Services or Items. Claims for payment of health care services or items shall only be submitted after the services or items have been documented by the provider. It is the responsibility of each CMA clinical Department to ensure that documentation exists before health care services or items are billed.

3. Amendment or Correction of Medical Record. The following standards apply to amendment or correction of a CMA patient's medical record.

   - No portion of a medical record may be removed, destroyed, or obliterated (e.g., use of correction tape, correction fluid, black marker, inked out).

   - If necessary to correct any entry after it has been authenticated, the entry shall be corrected by drawing a single line through the incorrect entry so that it is still legible and inserting the correct information, dating and signing the corrected entry. The date the correction is made shall be the date of the correction, not the date of the original entry.

   - The provider adding an addendum or amendment to the medical record shall sign and date the entry. The date shall be the date that the addendum or amendment is made, not the date of the original entry.

   - Addenda or amendments for non-clinical purposes (e.g., to clarify the services provided) shall not be made to the medical record after the service has been billed without the prior written approval of the Creighton Compliance Director.

4. **Re-creation of Lost Patient Records:** Although it is rare, any lost patient record shall be recreated to the greatest extent possible. The record shall reflect that it is recreated, noting the dates covered in the recreated patient record. Recreated entries shall be dated as of the date they are entered

into the medical record. Any entries which cannot be recreated shall be identified by date and type of service (i.e. office visits, phone calls, etc.). The recreated patient record shall identify the last known location of (or person having possession of) the original patient record.

B. Effect of Official Demand for Record or Pending Investigation or Legal Action

1. No medical record shall be removed or taken offsite, replaced, destroyed, altered, amended or supplemented after a subpoena, civil investigative demand, or other official demand for the record has been received.

2. No medical record shall be removed or taken offsite, replaced, destroyed, or altered if an investigation or administrative or legal action is pending and the medical record is known to have any relationship to the pending investigation or action, regardless of whether or not the record has been demanded or subpoenaed.

3. A medical record that has any known relationship to a pending investigation or administrative or legal action may only be amended or supplemented for legitimate medical reasons upon written permission of General Counsel and subject to the terms of this policy.

V. ADMINISTRATION AND INTERPRETATIONS

Questions regarding this policy may be addressed to Department Administrators, the Compliance Director or General Counsel.

VI. AMENDMENTS OR TERMINATION OF THIS POLICY

This policy may be amended or terminated at any time.

VII. REFERENCES

Metro Omaha Medical Society Physician-Attorney Guidelines (1995); CMS's 1995 and 1997 Documentation Guidelines for Evaluation and Management Services (http://www.cms.hhs.gov/medlearn/emdoc.asp)