

# ***Policies and Procedures***

<b>SECTION:</b> <b>Administration</b>	<b>NO.</b> <b>2.5.4.</b>		
<b>CHAPTER:</b> <b>Billing Compliance</b>	<b>ISSUED:</b> 02/01/2020	<b>REV. A</b>	<b>REV. B</b>
<b>POLICY:</b> <b>Health Record Documentation</b>	<b>PAGE 1 OF 7</b>		

## **PURPOSE**

To ensure proper documentation of health care services and items provided to patients by Creighton University physicians, residents, non-physician practitioners, ancillary staff and students. Proper medical record documentation not only supports treatment and continuity of care but also supports reimbursement, provides data for public health purposes and benchmarking, serves as a resource for healthcare practitioner education, documents evidence of the quality of patient care, and serves as a legal business record.

## **POLICY**

A complete and accurate medical record shall be maintained for each individual who is evaluated by and/or receives clinical treatment from any Creighton University clinic facility or otherwise as a registered patient of any Creighton University clinic or facility (e.g., by telephone or electronic means).

## **SCOPE**

This policy applies to all Creighton University employees, faculty, residents, students and agents working on behalf of Creighton University who make entries in the medical record, whether in electronic or paper form, in a Creighton University owned and operated clinic. While the basic principles of medical record documentation contained herein apply in other settings, entries in a patient's medical record in locations other than a Creighton University clinic (e.g., hospitals, skilled nursing facilities, and other contracted sites) are subject to the medical record policies of the specific location.

## **PROCEDURES**

### **1. Content of the Medical Record**

- a. Any medical information produced as a result of assessment and/or treatment of a patient (whether in person, by telephone, or by electronic means) must be made part of the patient's medical record. The exact content of the record will depend on the nature of the service provided. This section provides a brief summary of basic medical record content requirements. Other University policies continue to apply and may dictate a specific content (e.g., Teaching Physician Policies and Procedures).
- b. Nebraska law requires each health clinic to maintain records and reports in such a manner to ensure accuracy and easy retrieval.
  - i. Every patient who receives care or treatment in a health clinic must have a medical record established. Medical records must contain sufficient information to clearly identify the patient and document the diagnosis, care, treatment, and results accurately.
  - ii. Medical records must contain, when applicable, the following information: identification data; chief complaint; medical history; physical examination; all

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pathology/laboratory and radiology reports; properly executed informed consent forms; consultation reports; medical practitioner orders; care and treatment provided; progress notes; pertinent observations and events; and instructions to patients, including discharge/dismissal.

- iii. Medical records must contain entries which are dated, legible, and indelible. The author of each entry must be identified and authenticated. Authentication must include signature, written initials, or computer entry.
- c. In addition, medical record 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 the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. As per the Guidelines, the principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For evaluation and management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.
  - i. The medical record should be complete and legible.
  - ii. The documentation of each patient encounter should include:
    - 1. Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
    - 2. Assessment, clinical impression or diagnosis;
    - 3. Plan for care; and
    - 4. Date and legible identity of the observer.
  - iii. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
  - iv. Past and present diagnoses should be accessible to the treating and/or consulting physician.
  - v. Appropriate health risk factors should be identified.
  - vi. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
  - vii. The CPT and ICD-10 codes reported on the health insurance claim form should be supported by the documentation in the medical record.

## **2. Users and Authors**

- a. Only authorized individuals shall make entries in the patient's medical record.
- b. Authorized individuals shall stay within their authorized role in the medical record.
  - i. Teaching physicians and residents may document physician services in the patient's medical record. The documentation must be dated and contain a legible signature or identity and may be completed using one of these methods:
    - 1. Dictated and transcribed
    - 2. Typed

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3. Hand-written or
4. Computer-Generated
- ii. Requirements of Teaching Physician: You may use a macro, which is a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text that is not edited by the user, as the required personal documentation if you personally add it in a secured or password-protected system. In addition to your macro, either you or the resident 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. If both you and the resident use only macros, it is not considered sufficient documentation.
- iii. When billing for E/M services, the teaching physician must personally document at least all of the following:
  1. That he or she performed the service or was physically present during the critical or key portions of the service furnished by the resident and
  2. Participation in the management of the patient
- iv. On medical review, the combined entries in the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service. Documentation by the resident of the teaching physician's presence and participation is not sufficient to establish such presence and participation.
- v. E/M Documentation Provided by Students
  1. Any contribution and participation of a student to the performance of a billable service (other than review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or the physical presence of a resident in a service that meets the requirements in this section for teaching physician billing. Students may document services in the medical record; however, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical-decision-making activities of the E/M service being billed and may verify any student documentation of them in the medical record rather than re-documenting this work.
- c. Authorized users of the electronic health record (HER) shall enter information only under their own usernames/NetIDs and passwords (collectively, "log-in"). Sharing of log-ins is prohibited and may result in disciplinary action. Entering information under another user's log-in is prohibited and may result in disciplinary action.

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- d. Each person is responsible for the completeness, accuracy and veracity of the information entered into the HER under his/her log-in.
  - e. Each author of a note in the HER is responsible for the overall content and timely signing/finalizing the document.
  - f. When a paper record is in use, clinical personnel entering into the record must:
    - i. Ensure his or her entry is legible.
    - ii. Use blue or black ink to create entries.
    - iii. Legibly sign each entry with credentials (e.g., M.D., D.O., H.O., ARNP, PA, M-3, M-4, RN). If the authors signature is not legible, the author is responsible for legibly printing his/her name and credentials under the signature or ensuring his/her Department has a signature log bearing his or her signature and name with credentials.
    - iv. Missing signatures in a paper record cannot be added at a later date. A signature attestation statement must be completed by the author and added to the record.
- 3. Timeliness of Entries in the Medical Record**
- a. Health care services or items should be documented during the service or as soon as practicable after the service or time is provided.
  - b. Billing Compliance Committee has extended management of timely documentation to the individual clinical departments and their policies; however, individual clinical department policies shall not exceed 5 business days from the date of the patient encounter.
  - c. Claims for services will not be submitted until the documentation for the service is finalized.
- 4. Amendments, Addenda, Late Entries, Lost Records**
- a. An amendment to the record is used to correct an entry after the original document has been signed/finalized.
    - i. Authors should ensure notes are complete prior to finalizing to avoid unnecessary amendments.
    - ii. Amendments to a record should not be used to add information that was not generated during the course of the documented encounter. Instead, an addendum note should be created.
    - iii. For paper records:
      1. No portion of a medical record may be removed, destroyed, or obliterated (e.g., use of correction tape, correction fluid, black marker, inked out).
      2. 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.
  - b. A late entry is documentation of a service that was not previously documented in a timely fashion. Any such entry should be identified as a late entry. Late entries are documented

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with the current date and time. The documentation for a late entry refers to the date and incident for which the late entry is being written.

- c. Although it is rare, any lost patient record shall be recreated to the greatest extent possible. The record shall reflect that 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 that cannot be recreated shall be identified by date and type of service (i.e. office visits, phone calls, etc.). The reason for loss of the record (e.g., corrupt note) should be documented in the recreated record. If the record is in paper form, the recreated note should identify the last known location of (or person having possession of) the original patient record. The HER vendor should be consulted if HER documentation is lost or corrupted to assist in recovery, if possible.
- d. 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 Billing Compliance Committee.

## **5. Documentation Shortcuts in the HER**

- a. Copying or pasting information from the documentation of a past service into the documentation of a current service is strongly discouraged. Any copying/pasting should be undertaken with great caution and the author of the note bears the responsibility for the accuracy, relevance and veracity of any copied/pasted information. If this function is used, it should be used only to include static information such as a complex diagnosis or procedure summary that is clinically useful to reference in the current encounter and only where other options to reference this information (e.g., creating an annotation to a diagnosis) are not feasible or efficient.
  - i. The authorized user copying or pasting information from a past encounter into a current encounter must review and verify the accuracy of any such information.
  - ii. Copying or pasting information from one patient's medical record into another patient's medical record is prohibited.
  - iii. Information may only be copied/pasted from within the same author's notes (i.e., information from another author's note may not be copied/pasted).
  - iv. Authors should review the accuracy, consistency and completeness of the documentation of an encounter before finalizing the note. For example, the author should ensure the Chief Complaint, History of Present Illness and Review of Systems (ROS) are consistent and that diagnoses for the encounter are supported within the record prior to finalizing the note.
  - v. A ROS and/or a Past Medical, Family and Social History (PFSH) obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by describing any new ROS and/or PFSH information or noting there has been no change in the information; and noting the date and location of the earlier ROS and/or PFSH noting there has been no

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change in the information; and noting the date and location of the earlier ROS and/or PFSH.

- vi. Teaching Physicians are permitted to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical-decision-making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.
- b. Templates, smart phrases and checkboxes must not take over documentation for the user. Clinical personnel must determine the information that needs to be in the record for each visit based on the actual services provided and the medical necessity of the services.
  - i. Authors should be familiar with the content of templates and the result of the checkboxes and other auto populating fields within the HER.
  - ii. Authors should review the accuracy, consistency and completeness of the documentation for an encounter before finalizing the note.

## **6. The Evaluation and Management Calculator**

- a. If an evaluation and management code calculator is found within the HER, it is to be considered only a tool to assist the billing provider in determining the CPT code to bill for an E/M encounter.
- b. The billing provider must consider the medical necessity of the service. As best summarized by Medicare, the medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.
- c. The billing provider for an encounter shall review the CPT Code suggested, consider the service as a whole including medical necessity, and verify the CPT Code suggested before submitting the encounter form in the HER.

## **ADMINISTRATION AND INTERPRETATIONS**

Questions regarding this policy should be addressed to the Billing Compliance Committee.

## **AMENDMENTS OR TERMINATION OF POLICY**

This Policy may be amended or terminated at any time. This Policy does not constitute a contract between Creighton University and its employees.

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### **EXCEPTIONS**

None

### **REFERENCES**

Nebraska Administrative Code Title 175 Section 7-006.07, Record-Keeping Requirements  
1995 and 1997 Guidelines for the Documentation of Evaluation and Management Services

### **VIOLATIONS AND ENFORCEMENT**

Any known or suspected violations of this Policy should be reported to the Billing Compliance Committee or to the Office of General Counsel. Violations of this Policy can result in disciplinary action in accordance with University policies including, but not limited to, the Compliance Plan for Health Sciences Billing and Patient Services.