<table>
<tr><td rowspan="2">
TITLE: Medical Record Completion (ORCHID)

DIVISION: Ambulatory Care Network (ACN)

SERVICE AREA/ UNIT: Medical Administration</td><td>Policy & Procedure Number</td><td>ACN
CD-01.021</td></tr>
<tr><td>Origination Date:</td><td>02/11/2021</td></tr>
<tr><td></td><td>Revision Date:</td><td></td></tr>
<tr><td></td><td>Review Date:</td><td></td></tr>
<tr><td></td><td>Approved By:</td><td>ACN P&P</td></tr>
</table>

1.0 PURPOSE:

1.1 Establish the guidelines for timely completion of medical records (visit documentation and other clinical interactions) by licensed independent providers and other clinical staff.

2.0 DEFINITIONS:

2.1 Completion: The process of *completing an entry* in the health record by which documentation related to the visit is completed by the provider. The signature is applied, and the entry is considered complete. An entry is complete when the Sign button is clicked.

2.2 Locked: The process by which visit documentation is deemed complete. Once "locked" any changes to the entry must be made through an amendment. Records will be electronically "signed" by the provider/staff when closed. Once locked the billing processes can be applied.

3.0 POLICY:

3.1 Every effort will be made to lock medical records within seven (7) business days of visit.

3.2 Medical records can only be accessed by staff in accordance with the level of their licensure and granted access level.

3.3 Prompt documentation of a medical encounter ensures:

3.3.1 Improved ability to accurately recall and document the encounter.

3.3.2 Timely availability for other members of the workforce so they can review the most recent plan, medical decision making or advice.

3.3.3 Reduction of unnecessary or duplicate testing, prescriptions or referrals.

3.3.4 Timely billing.

4.0 PROCEDURE:

4.1 Timely completion

4.1.1 All medical records will be complete, as defined above, and signed within seven (7) business days by individuals responsible for that encounter. If the

provider is going on vacation or will not be in the office for an extended period, all records must be signed before leaving on scheduled time off.

4.1.2 If a record is not closed within the required time limit, a reminder shall be sent to the provider. ACN will also regularly run monitoring reports to track compliance and follow-up with individual providers.

4.1.3 In instances of emergent or non-scheduled provider absence that exceeds 30 days, provider managers/supervisors need to ensure that the Provider Message Center is Proxied. If there are unsigned notes: the provider who has taken proxy will create list of unsigned notes to provide to Medical Director and will sign these saved notes "as-is" with a notation designating that the note has been signed as-is for publication only.

4.1.4 Providers will make every effort to ensure that the problem list, medication list, medication allergy list, orders, and any future appointments are documented prior to patient check out. Priority will be given to completing orders before patient check out. This will ensure the patient receives a Visit Summary with the most current recommendations.

4.1.5 To the extent possible, encounter documentation shall include the following minimum elements:

a. Chief complaint

b. History of Present Illness (HPI)

c. Review of Systems

d. Vital signs as appropriate

e. Exam as appropriate

f. Assessment

g. Plan of care consistent with chief complaint

h. Visit (Evaluation and Management) code

i. Follow-up plan

j. Telehealth notes require:

- Documentation of verbal patient consent for the visit
- Documentation of length of time for visit

4.1.6 Documentation of conversation and/or attempts to converse with the patient not associated with a visit (e.g., routine follow-up or after-hours coverage) should ideally be done as soon as the call is completed, but no later than 48 hours.

a. If the patient call is not resolved within 48 hours due to the inability to reach the patient (patient will not return calls, bad phone number, etc.) this information should be documented in the note, then closed and signed.

b. A new note can be started if the patient calls back after that time.

c. For abnormal results, where provider delegates notification to a team member, the team member will attempt to contact the patient/parent/guardian.

- If telephone contact is unsuccessful after at least three attempts, the requesting provider will be notified. The requesting provider will provide further direction

4.1.7 Recording Entries in the Medical Records

a. All entries in the medical record automatically identify the date and time of the entry. The date and time will identify when the entry is made, however the date and time of the event must be documented.

b. All entries in the medical record shall adhere to professional standards and best practices for documentation.

4.1.8 Abbreviations and Symbols

a. Standard and accepted abbreviations and symbols may be used in recording entries in the medical record.

b. A list of approved medical record abbreviations and symbols shall be maintained by the Health Information Management division and accessible on the ACN SharePoint.

4.1.9 Errors and Corrections

a. Errors in the medical record shall be corrected by creating an addendum and noting the error.

b. All corrections shall be time stamped with staff/provider name and date.

4.1.10 Verbal Orders (refer to Verbal Orders Policy & Procedure)

4.1.11 Signatures – Authentication

a. All documentation in the Electronic Health Record (EHR) will be electronically signed when the encounter is complete.

b. No person shall authenticate an entry for another person.

c. It is also acceptable for a covering physician to sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. All orders, including verbal orders, must be dated, timed and authenticated promptly by the prescribing practitioner or another practitioner responsible for the care of the patient, even if the order did not originate with him/her.

d. The covering physician is a physician of the same specialty as the attending or consulting physician who assumes responsibility for the care of the patient within a specific time frame.

4.2 Monitoring

4.2.1 Completion of charts will be monitored monthly by appropriate designee.

4.2.2 Report of unlocked records (delinquencies) will be communicated via email to providers, Medical Directors or designees, HIM manager.

4.2.3 Compliance reports will be presented to Credentialing and Privileging Committee and Quality Board.

4.2.4 Timely completion of charts shall be considered in the Ongoing Professional Practice Evaluation (OPPE) process.

4.3 Incomplete Medical Records and Delinquencies

4.3.1 The medical record shall be completed within seven (7) business days after the patient visit.

4.3.2 A provider should only complete a medical record on a patient that is familiar

to them. If they are going to retire (close) a record of another staff member the documentation should note that the provider is closing the record for another provider.

4.3.3 The Medical Director or designated supervisor, may retire the medical record as "incomplete" only if the physician is deceased, has moved from the area, has resigned from the medical staff, is on an extended leave of absence, or at the discretion of the professional staff committee. In this situation, the following statement will be added to the record: "Incomplete: Due to the departure/death/or permanent incapacitation of the health care provider the (name)_______ report is unavailable and this record is being filed incomplete by order of the Medical Director (name)___________".

5.0 REFERENCES:

5.1 Amendments, Corrections, and Deletions in the Electronic Health Record: an American Health Information Management Association Toolkit (2009) http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDoc Name=bok1_044678

5.2 Update: Maintaining a Legally Sound Health Record—Paper and Electronic http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDoc Name=bok1_028509

REQUIRED BY:

Meaningful
CMS

Prepared by: Guillermo Diaz, MD

Approvals:

8/5/2021

Quentin O'Brien
Chief Executive Officer

Date

8/5/2021

Margarita Pereyda, MD
Interim Chief Medical Officer

Date

8/5/2021

Debra Duran, RN
Chief Nursing Officer

Date

P&P HISTORY

Date	Department	Policy and Procedure No.	Comments	Next Annual Review Due
02/19/2020	ACN		Draft prepared	
02/11/2021	ACN	CD-01.021	Approved	
07/28/2021	ACN	CD-01.021	Approved	07/28/2024