



POLICY SUBJECT:

Medical Record Documentation

EFFECTIVE DATE: 08/12/2011

*To be reviewed every three years by
Compliance and Ethics Committee*

Policy on Medical Record Documentation

Purpose:

This policy clarifies specific documentation guidelines that pertain to medical records.

Definitions

1. Authentication - The identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.
2. Macro - 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.
3. Template - A document or file that exists in a preset format and is used as a starting point to guide a healthcare provider through the documentation of his or her services. The format is saved and available for future use to prevent the recreation of commonly used text.

Policy:

As with paper records, practitioners are responsible for assuring the accuracy, completeness and timeliness of all clinical documentation they contribute to an electronic medical record. All other Sound Physicians documentation policies apply to both paper and electronic medical records, including policies on Teaching Physician presence and documentation, timely documentation, and specialty/service-specific documentation (see References below).

- A. Templates - Templates may only be used as a prompting tool and may never substitute for providing encounter-specific documentation for each service. The following rules apply when using templates:

- Review by Sound Physicians Compliance - Templates used by multiple practitioners must be approved by the Compliance Department before the templates are used in the medical record. It is recommended that templates created solely for the use of an individual practitioner also be reviewed by the Compliance Department before implementation.
- Active Selection - Templates may only be used for billing purposes when the practitioner makes active selections in documenting his or her services. The following types of active selections are considered acceptable in an electronic template:
 - i. Check boxes.
 - ii. Drop down menus.
 - iii. Blank lines requiring the addition of new text.

B. Macros - Templates may include the use of macros. Per CMS, practitioners "may use a macro as the required personal documentation if he or she personally adds it in a secured or password protected system. In addition... [the practitioner] must provide customized information that is sufficient to support a medical necessity determination. The note in the medical record must sufficiently describe the specific services furnished to the specific patient on the specific date." All information imported into electronic medical records in this way must always be specific to the individual patient at the time of the encounter. Practitioners are encouraged to direct regulatory questions regarding the development and use of macros to the Compliance Department.

C. Copy and Paste/Copy Forward – Sound Physicians recognizes that the practice of copying and pasting or copying forward previously written documentation about a patient can improve the efficiency and completeness of clinical records. However, documentation created by this method must be accurate and complete. It must reflect the services provided to the patient on the day and time of the current specific encounter. If documentation contained in a clinical record is incomplete, contradictory, or otherwise does not accurately reflect the services provided at the current encounter, that documentation will not be used to support billing for those services. To assure accuracy, practitioners must take care to review the completed documentation carefully when information is copied into a new record.

Practitioners must not copy and paste content from notes created by any student except as follows:

- Any person may document Review of Systems or Past Family and Social History. If a practitioner relies on copy and paste content for these elements of a service, the practitioner also must personally document his or her review and verification of such information with the patient.

Copying and pasting or carrying forward phrases or sentences that have been composed by other health care professionals is acceptable if the content of the material also has been verified firsthand by the practitioner relying on that information as a source for his or her own documentation. If the practitioner has not personally verified the information, this must be noted in the record for billing purposes. If content written by another health care practitioner is copied into a note written by another, it is good practice and clearer to cite the author of the content.

- D. Authentication - All clinical services documented in an electronic medical record must be authenticated by the practitioner providing services. Failure to authenticate records may impact billing for such services.