Documentation improvement handbook for the medical staff:

An essential guide to documentation in the medical record

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and
Richard A. Sheff, MD
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Dedication

To all the physicians I have worked with over the years, especially Dr. Frank Gruber and Dr. James Allen.

— Jean S. Clark, RHIA
About the experts

Richard A. Sheff, MD

Richard A. Sheff, MD, serves as vice president of consulting and education for The Greeley Company. He provides consulting services in the following areas: hospital and medical staff performance improvement; managing poor quality and disruptive physicians; medical staff reengineering; strategic planning; credentialing and privileging; regulatory compliance; integrating complementary and alternative providers into hospitals and physician practices; managed care; and physician-hospital integration.

Sheff is a family physician with extensive experience in health care administration and managed health care. Board certified in both family practice and medical management, Sheff previously served as chief executive officer and medical director of CommonWell, Inc., a company that integrates complementary and alternative medicine with conventional medicine. Prior to working with CommonWell, Sheff served as vice president for medical affairs at Boston Regional Medical Center and its integrated delivery system. Sheff also served as past president of Boston Regional Medical Associates, Inc., a hospital-affiliated corporation that owned and operated physician practices.
In addition, he was the founder and a past president of a successful IPA on Boston's north shore and he previously served as the medical director of an affiliated physician-hospital organization through which he managed capitated contracts with Harvard Pilgrim Healthcare and Tufts Associated Health Plan, including Medicare Risk Capitation. Sheff served on the U.S. Healthcare Executive Committee for the New England region and has practiced in a Harvard Community Health Plan–affiliated family medicine group.

He teaches at Tufts University School of Medicine where he has had responsibilities for curriculum development, student advising and research, and has served as chair of the Massachusetts Academy of Family Practice Research Committee.

Jean S. Clark, RHIA

Jean S. Clark, RHIA, is the director of health information services at CareAlliance Health Services in Charleston, SC. She is also responsible for coordinating continuous JCAHO survey readiness. Her professional background includes being a member of the JCAHO Standards Review Task Force and the expert panel on the Information Management chapter and past president of the American Health Information Management Association (AHIMA) and AHIMA’s 2000 Distinguished Member. She is currently vice president of the International Federation of Health Records Organizations. She has served, both nationally and internationally, as a speaker on topics such as health records, confidentiality, risk management, JCAHO
standards compliance, diagnosis-related groups, quality, and performance improvement.

Her list of publications includes


- Contributing Editor, *Medical Records Briefing*, HCPro, Inc. (1999–present)


This handbook is a quick guide to physician documentation requirements in the medical record. It applies wherever records are generated. The following proverb makes up the basis of all documentation requirements:

“VOX AUDITA PERIT;
LITERA SCRIPTA MANET.”

“The spoken word perishes, 
The written word remains.”
–Latin proverb

This proverb reminds us that the information documented in the medical record provides the only real proof about the care and treatment provided to patients. The written medical record supports a host of activities, including all of the following:

- Communication between the doctor and the clinical team
- Follow-up care and referrals for additional treatment
- Verification of compliance with licensing and accrediting requirements at survey
Timely and accurate billing

Building a strong defense in the event of legal disputes and litigation

Therefore, the importance of accurate, complete, and timely medical records can not be overstated. Unfortunately, timely and adequately detailed completion of medical records is not always a priority in the busy life of the physician.

A word as we begin: Physicians are used to doing what it takes to get the job done. They care about their patients and will do the right thing even when they don’t want to. So let’s agree up front that nobody likes to fill out medical records. Let’s also agree that, for both physicians and the organizations in which they work, an adequately thorough, timely, and accurate physician medical record is the best tool to ensure three critical needs are met:

- Safe, high-quality patient care
- Reduced liability for physicians and the organizations in which they work
- Optimal and appropriate reimbursement

So, as good physicians always do, let’s get on with the job at hand.
Documentation requirements

Who determines what the physician documentation requirements are?

Generally these requirements come from federal, state, and local regulatory bodies, accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the medical staff's bylaws, rules, regulations, and policies.

How can I, as a busy physician, know what the important documentation requirements are?

This handbook will serve as a quick guide to these requirements. Also, your director of health information management, medical records, and your medical staff services professional can provide more information.
about the requirements. For additional information, including any recent changes to the requirements, please see the table of references at the end of this handbook.

Tips for knowing physician documentation requirements

1. DON’T try to know all the rules. There are too many.

2. DO know who accredits the facility where you practice.

3. Get to know the medical staff services coordinator and the director of health information or medical records department. They will know ALL the rules and will be monitoring your compliance.

4. Read the medical staff bylaws and rules and regulations and keep them handy. Better yet, get involved in their development. After all, they govern the medical staff so you need to have some ownership in what they say.

5. Obtain an electronic version of the bylaws and rules and regulations for ready reference on your computer.

6. Don’t try to get around the rules. It just never works out well.

7. Be available during surveys. Inspectors from regulatory and accreditation bodies like physician involvement. After all, you are the leader of the health care team.
What should a physician do if one regulatory body has a different requirement than another?

Unfortunately, such situations exist. When they do, you can expect to be held to the strictest standard. Authenticating verbal and telephone orders is a good example. JCAHO allows each hospital to determine its own time frame for authenticating verbal orders. Your rules and regulations may stipulate that physicians must authenticate verbal orders within 72 hours. However, some state regulations require that verbal orders be authenticated within 48 hours. If this conflict exists in your state, physicians must authenticate verbal orders within 48 hours because this represents the stricter of the conflicting standards.

What are the most important documentation requirements for physicians?

The table on p. 4 provides an overview of the most important documentation requirements for physicians. It also highlights specific time limits within which each documentation requirement must be met.
## Documentation requirements for physicians

<table>
<thead>
<tr>
<th>Documentation requirement</th>
<th>Time limits for documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide an adequately complete medical history and physical (H&amp;P) examination</td>
<td>A completed H&amp;P generally must be in the medical record within 24 hours after an admission and always before surgery.</td>
</tr>
<tr>
<td>Progress notes that adequately document the patient’s condition as well as the physician’s assessment and plan.</td>
<td>Timeliness standards for progress notes are usually defined in the medical staff rules and regulations. To ensure good quality of care and accurate documentation, physicians should — at a minimum—complete progress notes on the same day they saw the patient.</td>
</tr>
<tr>
<td>Orders</td>
<td>Orders need to be dated and sometimes timed to be able to verify whether they have been carried out in a timely manner. The time limit for authenticating verbal and telephone orders can be tricky because of conflicting requirements, so make sure you know the specific requirements for this one in your facility.</td>
</tr>
<tr>
<td>Informed consent to surgery/procedure/anesthesia</td>
<td>Informed consent must be documented in the medical record prior to initiation of the procedure or initiation of anesthesia.</td>
</tr>
</tbody>
</table>
## Documentation requirements for physicians (cont.)

<table>
<thead>
<tr>
<th>Documentation requirement</th>
<th>Time limits for documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operative/procedure report</td>
<td>Immediately after surgery.</td>
</tr>
<tr>
<td>Anesthesia record</td>
<td>Immediately prior to and immediately after surgery.</td>
</tr>
<tr>
<td>Autopsy report</td>
<td>May be defined in the medical staff rules and regulations.</td>
</tr>
<tr>
<td>Diagnostic reports</td>
<td>May be defined in the medical staff rules and regulations.</td>
</tr>
<tr>
<td>Discharge summary</td>
<td>Most often required within 30 days after discharge, though a different requirement may be delineated in the medical staff rules and regulations. However, optimal quality of care and communication among treating physicians and agencies caring for the patient are best served by physicians completing summaries as close to the time of discharge as possible, preferably within the same day.</td>
</tr>
<tr>
<td>Fully completed medical record</td>
<td>Usually, 30 days after discharge of the patient – may differ according to medical staff rules and regulations and state laws.</td>
</tr>
</tbody>
</table>
Timely completion

Why do some physicians repeatedly go on the suspension list? What can I do to make sure I'm not one of them?

All physicians with privileges to practice medicine must ensure their medical records are complete, accurate, and timely. Timely usually means completed upon providing care, as much as possible, but in all cases within no more than 30 days after discharge. The medical staff rules and regulations usually state this requirement. In order to communicate the seriousness of this requirement and maximize compliance, most medical staffs have implemented a policy that stipulates that if a physician fails to complete one or more medical records within 30 days of discharge, the physician’s privileges are automatically suspended until he or she completes the records.

Medical staffs have taken this step because given the competing and incessant demands on physicians, the “carrot” approach usually fails and this “stick” approach has been necessary. To stay off the suspension list, a physician only has to stop in the medical records department at least once every 30 days and complete all outstanding medical records at that time. Responsible physicians make time to do this once a week, which makes it a much shorter stop. In fact, most physicians make time to complete their records in a timely manner, and only a small number of physicians account for
1. Document at the point of care—don’t procrastinate.

2. Use pre-printed forms whenever possible.

3. Embrace computer applications.

4. Go to the health information management or medical records department every week and complete records.

5. Remember, authenticating (signing) the entry is just as important as the documentation.

6. Be a partner with the health care team in designing forms and computer screens.

7. Avoid the delinquent list.

8. Be a champion for accurate, timely, and legible medical records.
Handwriting and legibility

As a physician, I am often in a hurry and sometimes my handwriting can be difficult for others to read. Just how big a problem is this?

It turns out to be a very big problem. In fact, a significant proportion of medical errors can be traced back to poor legibility of physician handwriting. At least one physician has been successfully sued for negligence when his poor handwriting on a prescription led a pharmacist to dispense the wrong medication and a patient died as a result. It’s common sense that the very professionals you count on to carry out your orders or participate in the coordinated care of your patient should be able to read your orders, progress notes, and other record entries. If you don’t document in a consistently legible fashion, you are not fulfilling your responsibility to communicate adequately with the treatment team. Poor handwriting results in a much higher risk of a medical error and a liability suit for you and your facility. When it comes to legibility of medical record entries, the physician must shoulder the burden. So whether you need to slow down, print, take a penmanship class, or arrange to dictate your chart entries, just do it.
Liability protection

Nobody likes to be sued and nobody likes to lose a malpractice lawsuit. How can good physician documentation protect me and my facility from liability?

When it comes to litigation, an ounce of prevention is worth much more than a pound of cure. The medical record is the most important legal document in any liability suit. The rule of thumb is, “If it is not in the record, it didn’t happen.” Also, if an entry is made some time after the event it describes (such as an operative note, discharge summary, or progress note) the validity of the entry can be challenged in a court of law. Memories fade, and

Tips for improving legibility

1. Use pre-printed forms or templates whenever possible.
2. Be willing to take a penmanship class.
3. Print or use a transcriptionist.
4. Embrace the electronic medical record.
should any case come to litigation, the medical record will be your primary source for recalling facts related to care and treatment. Today, anybody can sue you for anything. But an adequately thorough, legible, and timely medical record makes it much less likely you will be sued, and much more likely that if sued, you will prevail.

Tips for minimizing liability

1. Document at the point of care and as soon as possible after discharging the patient. You won’t remember later.

2. Time, date, and authenticate entries.

3. Write legibly.

4. Document factually; don’t criticize or blame others.

5. Make sure your entries are adequately thorough to reflect sound clinical thinking. (You may ultimately have been wrong, but if you used and documented sound clinical thinking, it is much harder for a court to hold you liable.)
Informed consent

Speaking of liability, what are the best practices for documenting informed consent to minimize liability for myself as the treating physician and the facility?

Informed consent for a procedure or anesthesia is a process between the physician and the patient, according to current legal opinions. As a physician, you have the responsibility to document that you discussed your assessment and recommendations with the patient, including the risks and benefits of the recommended course of treatment and other treatment options. If this discussion occurs between the physician and the patient (and sometimes the patient’s family), it stands to reason that the physician should document this activity in the medical record. All too often physicians count on a hospital’s or other facility’s staff to obtain a patient’s signature on an informed consent form as adequate documentation.

Best practices today involve the physician sitting down with the patient, including his or her family if appropriate, and dedicating adequate time and attention to the process of obtaining informed consent.

Immediately after this activity, the physician should document in the medical record that the activity occurred and include a brief summary of the content that was discussed.
The physician's medical record entry is the most important element of documenting adequate informed consent. Obtaining a patient's signature is secondary, but it does provide a degree of added protection. Some physicians even ask the patient to sign the physician's chart entry describing the informed consent.

Perhaps the strongest protection can be provided by a chart entry that includes a diagram of the anatomy and the planned procedure accompanied by a description of the risks, benefits, and alternatives discussed, as well as a statement by the physician describing the process of obtaining informed consent, with this entire chart entry cosigned by the patient.

The most common practice—that of having a member of the facility's staff obtain a patient's signature on an informed consent form—provides the least protection, since the person obtaining the signature usually did not participate in the process of obtaining informed consent.
Tips for documenting informed consent

1. Personally document in the medical record that you—the treating physician or surgeon—provided the patient with a description of your assessment and treatment recommendations, including a description of the risks and benefits of your recommended approach and any alternatives.

2. Don’t count on the facility’s staff to obtain a patient’s signature on an informed consent form as your primary documentation of the informed consent process.

3. If the potential for a language barrier exists, document in the medical record how this was adequately addressed.

Reimbursement and the medical record

How does physician documentation affect reimbursement both for the physician and the facility?

Third-party payers view physician documentation as the most important determinant of how much they will reimburse both the physician and the facility. First of all, third-party payers generally only have to reimburse for “medically necessary services.” The content of the medical
record provides the only source of information to determine whether a service is medically necessary. Therefore, physicians must document their findings and assessments in enough detail to validate the medical necessity of each admission, procedure, or transfer to a different level of care. Failure to do so may lead to a denial of payment to both the physician and the facility.

The level of reimbursement depends on the specific codes for care that the physician and facility submit to the third-party payer. Coders rely completely on documentation in the medical record as the basis of selecting codes for submission for payment. Physicians must learn the key elements of physician documentation that impact reimbursement for the common conditions treated by the physician’s specialty.

Finally, delays in physician documentation (such as in dictating the H&P, operative report, and discharge summary) can lead to delays in submission of claims and payment to the physician or the facility.
I hear my facility is planning to implement an electronic medical record (EMR). What does this mean for me?

This means better times—eventually. Until we all get there, however, there will be plenty of bumps along the way.

Tips for accurate and timely coding, billing, and reimbursement

1. Document when the care is provided.

2. Understand that H&Ps, operative reports, diagnostic tests, and treatment orders are critical for accurate coding.

3. Document the patient’s severity of illness and your clinical rationale for ordering the intensity and level of care you are prescribing.

4. Be open to suggestions on appropriate language for documentation made by case managers and coders in your facility.

5. Never compromise your integrity in the service of improving reimbursement; always document accurately.
the implementation road for an EMR. In spite of these
bumps, there is no avoiding it: If you’re not already using
one, an EMR is in your future. Physicians can and should
play a vital role in the development and implementation of
the EMR in your facility. But be prepared for frustration
because physician documentation is often the last piece of
the EMR pie to be implemented in health care facilities.
That’s why there is more electronic medical recordkeeping in
many physician offices than in hospitals. Even if the hospital
is not paperless, it often uses pieces of an EMR. Examples
might be online access to transcribed reports such as H&Ps,
radiology and lab reports, electronic signature capability,
and nursing documentation such as flow charts and assess-
ments.

As the leader of the health care team, the physician holds
the key to the success of any EMR application. So when your
facility starts including physician documentation or comput-
erized physician order entry (CPOE) in its electronic medical
records, make sure you support this initiative and provide
appropriate physician input during the design process. Even
if you are computer-phobic, a well-designed EMR will
improve your work flow and your patients’ clinical out-
comes. Built-in decision support services embedded in an
EMR and CPOE will, in the long run, make you a better
doctor and translate into safer care for your patients.
Performance improvement

Of all the things on which we could focus our performance improvement activities in health care today, I don't understand why improving physician documentation should seem so important. Why should I spend any of my scarce time and energy on improving my personal documentation or the documentation of my fellow physicians?

Tips for working effectively with an electronic medical record

1. Consider an EMR for your office practice.
2. Find out what is available where you practice and take advantage of the EMR capabilities in the facility.
3. Volunteer for the EMR design team and let your voice be heard.
4. Be a champion for the EMR even if you are not a computer expert.
5. If you are not already computer literate, take a computer course.
Physicians often don’t understand the full impact that poor documentation has on patient care, their health care facility, and on their own liability. Improving physician documentation improves patient safety, reduces liability, and improves the bottom line for both physicians and the facilities in which they work. In today’s difficult world of health care, those are some of the most important opportunities for improvement.

**Tips for performance improvement in physician documentation**

1. Work with performance improvement or health information management staff to develop meaningful indicators.

2. Agree to do record reviews, but insist on the process being convenient to your schedule and an efficient use of your time.

3. Be a solution to this issue, not a roadblock.
Privacy and confidentiality

A note on the confidentiality and security of medical records:
In today's environment, this handbook would be remiss if it did not mention confidentially and security related to medical records. It has always been the responsibility of the medical staff and other members of the health care team to safeguard the patient's privacy and the confidentiality of personal health information.

The JCAHO has long had standards related to this subject. Recently the federal government placed into law the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires all health care providers to comply with strict privacy and security rules related to a patient's protected health information.

The public's awareness of its rights to privacy and confidentiality of health information has increased, as have the penalties for violating these rights. Be sure to protect the confidentiality and security of medical records that come into your hands at all times.
Tips for medical record confidentiality and security

1. Safeguard medical records—don’t leave them lying around where unauthorized people can gain access.

2. Don’t discuss patients in hallways, elevators, cafeterias, or any other public areas.

3. Don’t release information without patient or legal representative authorization.

4. Don’t take offense if asked to provide proof of your need to receive or review a patient medical record.

In closing . . .

Keep in mind that complete, accurate, and timely medical record documentation helps:

• ensure patient safety and the continuity of patient care

• protect you and your health care facility in the event of legal action
• ensure third-party billing information is complete, accurate, and timely

• ensure compliance with accreditation requirements, applicable laws, and medical staff requirements for privileges to practice in a health care facility of your choice

Accuracy of clinical information is critical to patient care, accounting needs, and compliance with rules and regulations. Studies suggest that documentation completed relatively close to the events described is usually far more accurate than that which has been delayed. It is your responsibility to make accurate, complete, and timely medical records an important part of your privilege to practice medicine.
Helpful resources

www.jcaho.org
www.cms.gov
www.ahima.org
www.himinfo.com