Title: Record of Care, Treatment, and Services - Provider
Content of the Medical Record Policy - Policy

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Last Approved Date: 05/29/2015
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I. Policy Statement
   a. To ensure a complete and accurate record of care provided by the provider is available on all patients registered for care at University of Missouri Health Care (MUHC).
   b. Medical record documentation shall be developed electronically or on paper and maintained for each patient registered for care from MUHC. This documentation will be kept for 21 years from the time of the last visit at MUHC.

II. Definitions
   a. Not Applicable.

III. Process/Content
   a. Authority of Content:
      i. Documentation filed or stored in the legal medical record shall be subject to the oversight of the Patient Health Information Record Committee (PHIRC).
      ii. The Health Information Services (HIS) will maintain a database of documentation approved to be included in the patient's medical record. This may include: documentation of inpatient visits, ambulatory surgery visits, observation visits, outpatient clinic visits, emergency center visits, short stay center visits, symptom evaluation unit, ancillary testing and other significant provider/patient interaction.
      iii. A filing number in the lower left corner of a form, indicating approval for inclusion in the medical record, shall be on any form created on paper and either scanned into the Electronic Medical Record (EMR) or included as part of the paper medical record.
      iv. Documentation from ambulatory clinic visits may be stored in an ambulatory services medical record volume, subject to approval of the PHIRC, using the patient's facility based medical record number. This information will be maintained as part of the official medical record and will be made available upon request at the time of any admission at any MUHC facility.
b. Patient Identification:
   i. Each patient shall be given a unique, identifying number. All electronic
documentation for that patient shall be assembled and filed under that number,
thereby constituting a unit record. Each facility may maintain paper records,
subject to the approval of the PHIRC, assembled under the facility based medical
record number.
   ii. The medical record shall contain identifying information for the patient to
include, but not necessarily be limited to:
       1. Name (First, Middle, Last)
       2. Medical Record Number and/or unique identification number
       3. Date of Birth
       4. Current Address
       5. Legal Representative
       6. Social Security Number (if available)
       7. Gender
   iii. Each page of each document in the medical record must be identified with the
patient's name and unique identification number or facility based medical record
number.

c. Completion Requirements for Medical Record:
   i. A medical record will be considered complete when all requirements have been
met in accordance with the Rules and Regulations of the Medical Staff Bylaws.
Required documents for completion of a hospital visit include admission note or
update, discharge summary or note, discharge orders/instructions, operative
reports when applicable, countersignature of verbal orders and documentation of
a final diagnosis. Required documents for completion for clinic visits and
emergency center visits include visit note and documentation of a final
diagnosis.
   ii. The Attending Physician at discharge is responsible for completion of the medical
record.
   iii. Medical record will be considered delinquent 21 days following
discharge/visit.
   iv. The hospital's delinquency rate will include the following patient types: Inpatient,
Trauma, Observation, Short Stay, and Ambulatory Surgery. Emergency Department
and outpatient clinic visits will each be reported separately. Delinquent records will
be reported to the Department Chair, Hospital Chief Operating Officer,
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Documentation Management Committee (DMC) and the Executive Committee of the Medical Staff.

d. Timely Completion Guidelines:
   i. A history and physical exam (also called Admission Note) must be performed within 24 hours of admission on any patient admitted to the hospital for inpatient or observation services, and prior to an operative/invasive procedure performed in an inpatient or outpatient setting. If the history and physical exam was performed within 30 days prior to any admission status listed above, an updated history and physical exam must be performed and documented in the record within 24 hours of admission and reference the original history and physical exam. Both the original Admission Note and the update to the Admission Note must be dictated or created electronically.
   
   ii. Discharge Summaries must be dictated/created within 72 hours of discharge.
   
   iii. A completed operative report or operative note shall be included in the medical record immediately after surgery and before the patient is transferred to the next level of care. If an operative note was written, a complete operative report shall be generated for inclusion in the medical record.
   
   iv. The practitioner must authenticate by written signature or electronic signature key portions of the medical record for which he/she is responsible. Verbal orders for medications are authenticated as soon as possible but no longer than 48 hours from the time the order was given.

e. Authenticate/Counter Signature:
   i. History and physical, consultations, discharge summary, discharge orders/instructions and op note must have a countersignature. The Attending Physician must authenticate the discharge summary, final diagnoses and procedures recorded, and any operative notes.
   
   ii. All record entries made by students must be countersigned by the responsible licensed, registered or certified practitioner. All record entries must show author, date (day, month, year), time and signature authentication.
   
   iii. Attending Physicians must provide evidence in the medical record on a daily basis of the supervision of House Staff.
   
   iv. All scribing must be in compliance with use of Scribes in Clinical Documentation Policy.

f. Specific Medical Record Document Requirements:
   i. Documents which must be in electronic format include: Admission Note, Discharge Summary, Discharge Orders/Instructions, Consultation Notes, and Operative Notes. All updates and addenda must be created electronically.
A Summary of elements to be included in each document is listed below. See Record of Care, Treatment, and Services - Provider Content of the Medical Record Policy - Policy Appendix A for further details.

1. Admission Note:
   i. The documentation of any condition identified on the initial assessment or during continued testing as being present on admission should indicate the condition was present on admission.
   ii. An admission note contains the following information:
       1) Chief Complaint
       2) History of Present Illness
       3) Past Medical/Surgical History
       4) Allergies
       5) Medications on Admission
       6) Social History
       7) Family History
       8) Review of Systems
       9) Physical Examination
       10) Laboratory and Radiographic Results
       11) Assessment and Plan

2. Operative Note:
   i. The medical record documentation for operative or other high-risk procedures and the use of moderate or deep sedation and anesthesia includes:
       1) Operative or other high risk procedure report
       2) Patient’s hospital identification
       3) Date of the operation
       4) Inclusive or total time of the operation
       5) Names of the surgeon and any assistants
       6) Pre-Operative and post-operative diagnosis
       7) Name of the procedure performed
       8) Description of the Procedure
       9) Type of anesthesia Administered
       10) Findings of the procedure
       11) Any estimated blood loss
       12) Any specimens removed
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13) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any significant surgical tasks conducted by practitioners other than the primary surgeon

14) The operative report must be dated and authenticated by the surgeon

15) Post-Operative Information

16) Patient’s vital signs and level of consciousness

17) Any medications including intravenous fluids and any administered blood, blood products, and blood components.

ii. Medical records of patients undergoing invasive procedure must contain documentation as required by the sedation and analgesia policy. The use of approved discharge criteria to determine patient’s readiness for discharge is documented in the medical record and includes the name of licensed independent practitioner responsible for discharge.

iii. If a progress note is entered because an Operative Note has not been completed, the written note must contain: names of the primary surgeon and assistants, procedures performed, description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

iii. Progress Note:

1. Conditions that are acquired during the hospital stay that are considered Hospital Acquired Conditions by the Centers for Medicare and Medicaid Services should be documented by the responsible physician.

iv. Discharge Summary:

1. The medical record must include a discharge summary for each inpatient stay, observation stay, and short stay patients recovering on an inpatient unit.

2. The Discharge Summary consists of three components: Admission Note, Discharge Summary and Discharge Orders/Instructions. The Discharge Summary may be created as three separate documents, but must contain all of the required elements.

3. A final progress note may be substituted for the discharge summary only for patients with minor problems or interventions as defined by the Medical Staff Bylaws. The final progress note must include chief complaint, history of present illness, final diagnosis, pertinent lab and radiology results,
treatment including operations, course and results of treatment, condition of patient at discharge, discharge medications, physical activity, diet and follow up care.

4. The Discharge Summary component must contain, at a minimum:
   i. Procedures performed and treatment given
   ii. Reason for hospitalization or history of present illness (may refer to Admission Note)
   iii. Pertinent laboratory and radiographic results
   iv. Hospital course and results of treatment

v. Discharge Orders/Instructions:
   1. Discharge orders/Instructions must be completed for each inpatient stay, observation stay, and short stay patients recovering on an inpatient unit.
   2. Discharge Orders Instructions must be created electronically and must include:
      i. Name of provider completing Discharge Order
      ii. Name of provider to complete the discharge summary
      iii. Allergies
      iv. Medications at discharge
      v. Referring Physician
      vi. Primary Care Provider
      vii. Date of Admission
      viii. Reason for Admission
      ix. Attending Physician
      x. Date of Discharge
      xi. Principal Discharge Diagnosis
      xii. Secondary Discharge Diagnoses
      xiii. Condition of patient on discharge
      xiv. Discharge disposition
      xv. Any patient instructions including activity ad diet
      xvi. Special instructions
      xvii. Follow up care, including home health services or durable medical equipment
      xviii. Immunizations given
      xix. Follow up appointments
      xx. Notify physician if specific symptoms appear
      xxi. Physician Contact Information

vi. Clinic Notes:
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1. See Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_A_Document information required based on visit type - Form

vii. Emergency Department Notes:

1. See Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_A_Document information required based on visit type - Form

g. Electronic Documentation Guidelines

i. The provider signing a note is responsible for the accuracy and medical necessity of all information contained in the note. Notes that have not been read and reviewed should not be signed.

ii. Errors in documentation to be avoided include:

   1. Use of unapproved or prohibited abbreviations
   2. Unnecessary information (due to copying and pasting without editing)
   3. Incorrect information (due to copy to new note without editing)
   4. Missing information
   5. Failure to document reasoning for the assessment and plan

iii. The provider must verify and correct all information transferred by copy and paste (including copy to new note) if it is to serve as documentation on the new date of service. Otherwise, information copied from a previous note must clearly indicate the date of the previous note, who performed each service, and the author.

iv. Information copied from a previous note must clearly indicate who performed each service, and the author of the note must be identified.

   1. Attending teaching attestation statements must not be copied.

v. Providers should cite and summarize applicable lab data, pathology, and radiology reports rather than copy such reports in their entirety into the note.

vi. Providers intending to bill for their interpretations of data (e.g. lab, pathology, radiology) should indicate clearly that this is an interpretation.

vii. Photographs of patients will be stored in the Cerner Multi Media application and must be attached to a document in order for the photograph to become a part of the patient’s legal medical record. (See also policy Photography and Video Recordings of Patients and Victors.

viii. Once an electronic note has been signed as final, additional information may only be added as an electronic addendum or by using the correct function.

   1. Attending’s seeing patients with residents must use the appropriate compliance approved teaching addendum.
2. Only the original author and the attending may correct or add addenda to the note. Others must create a new note or message.

ix. Documents must be stored in the appropriate folder (event code) in the EMR as specified in Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_B_List of Documents in PowerChart and Where They are Stored - Form.

x. Documents placed in the wrong folder (event code) or visit (FIN) must be "in errored" by the author and a new document placed correctly.

h. Documentation Privileges:
   i. Documentation privileges are granted based on role (e.g. attending, resident, nurse,) and are summarized in Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_C_Document Privileges Granted Based on Position - Form.

IV. Attachments
   a. Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_A_Document information required based on visit type - Form
   b. Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_B_List of Documents in PowerChart and Where They are Stored - Form
   c. Record of Care, Treatment, and Services - Provider Content of the Medical Record_Appendix_C_Document Privileges Granted Based on Position - Form

V. References, Regulatory References, Related Documents, or Links
   A. The Joint Commission Accreditation Manual
   B. Rules and Regulations of the Medical Staff Bylaws
   C. Centers for Medicare and Medicaid Services- Hospital Acquired Conditions
   D. Record of Care, Treatment, and Services - Use of Scribes in Clinical Documentation Policy - Policy