Health Information Management—
Clinical Documentation Requirements

Specific Provider Documentation Requirements

The "Documentation Standards for Clinicians" policy and the "Documentation Standards in the Medical Record" policy outline the following timeliness requirements for these specific documentation types. Also indicated below are the specific requirements for each of the documentation types.

Documentation Type	Documentation Requirements
Consultation Report	• Within 24 hours of consultation
History and Physical	• Within 24 hours of admission or placement in observation status; or • Within 30 days of admission, placement in observation status, procedure, or operation, provided that an update noting any changes in the patient condition is completed within 24 hours of admission: and • Prior to any operation or procedure, and all required elements are included
Immediate Post-Op Note	• Immediately after the procedure or operation **and** before the patient moves to another area of care (recovery). • An operative note is acceptable in lieu of the immediate post-op note if completed and available in the patient's chart prior to the patient being transferred to the next level of care. • All required elements must be completed. If the required element is not applicable to the procedure, then NONE or N/A must be noted in the field. • An Attending Signature or Attestation is not required.
Narrative Discharge Summary	• Within 3 days of discharge for all patients discharged (except same day surgery patients without an overnight stay). • Also required to be completed if patient dies during hospitalization. • If the Discharge Summary will be dictated, the date of service must be dictated to reflect the date of discharge.
Operative Report	• Upon completion of the operative or high-risk procedure and before the patient is transferred to the next level of care unless an Immediate Post-Op Note is completed, in which case the full Operative Report can be written or dictated within 24 hours of the operation. • If the Operative Report is dictated, the date of service/procedure must be included in the dictation to reflect the date of the procedure.

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Documentation Type	Documentation Requirements
Outpatient Visit Documentation	• Within 4 business days of the encounter the provider note, meds reconciliation, orders, procedure notes, and clinical summary must be completed.
Progress Notes (for patients in the hospital setting)	• Progress Notes are documented at least daily by the service of the primary attending.
Anesthesia Documentation	• Pre-anesthesia evaluation within 48 hours prior to surgery or procedure utilizing anesthesia services. (This is required in addition to the proceduralist's History and Physical for the encounter.) • An intraoperative anesthesia record. • Post- anesthesia visit and evaluation no later than 48 hours after the procedure.
Emergency Department Documentation	• Documentation must be completed within 24 hours of the patient's emergency care visit.

Orders

- Each order, whether hand-written or electronic, requires, at a minimum the following information:
    - Patient name and medical record number;
    - Test, service, procedure, or therapy requested;
    - Reason for test (i.e., medical necessity);
    - Authentication (signature) by the ordering physician/provider;
    - Date of and time the ordering physician/provider authenticated the order;
    - Date and time along with the name and title of the individual receiving the order, in the case of a verbal order.
- Electronically entered orders are preferred. Orders issued via voicemail, text messaging, and emails are not permitted.
- Orders may be either directly entered by the authorized provider, entered by an authorized individual after a written request by the provider, or entered as a verbal order, where the order is verbally relayed to a staff member who is appropriately authorized to receive verbal orders.
- Verbal orders are reviewed and authenticated by the Provider who initiated the order or by another Provider member of the team caring for the patient as soon as possible, but no later than **48 hours** after the verbal order was given.
- Verbal Orders for medications and invasive testing or procedures are only utilized in situations where direct entry into the ordering system by the ordering Provider is not possible or feasible, such as when expediting urgent care for a patient in an emergency situation, or when the ordering physician does not have access to the ordering system, and the delay could compromise patient care.
- Verbal Orders are permitted in situations where their use supports more efficient work flows; however, they should also be limited where practical so as to avoid errors in

interpretation. All elements that comprise a valid Verbal Order are required to be incorporated in the Verbal Order by the ordering Provider.

- Verbal Orders for routine, noninvasive services and tests (e.g., lab, imaging) that are requested through direct verbal communication between the Provider and Receiver are entered into the approved CPOE system by the Receiver. All orders must be authenticated within 48 hours by the Provider.
- Any change or addition to a service or test requires a new Provider order except for certain Radiology orders as defined in the Provider Orders policy.
- Outpatient orders are valid for any specified period of time but not more than one year from the date of the order. Hospital orders (inpatient or observation status) are valid for any specified period of time, but not longer than the time of discharge from the hospital.
- Protocol or standing orders are initiated by a Provider for a specific patient after assessment of each patient's unique medical condition or if after clinical evaluation it is determined that the patient meets the general criteria of the protocol. The Provider is required to authenticate the order based on the protocol (within 48 hours of initiation).

Clinical Documentation

All clinical documentation must be completed within **14 days** from the patient encounter, or it is considered delinquent. Delinquent medical record documentation will be escalated through the appropriate clinical leadership structure. All deficiency information/details will display in the Epic Hospital Chart Completion Folder within the in-basket.

Deficiency	Contact	Email address
H&P	Janie Linder	janie.e.linder@vumc.org
	Tai Luu	tai.n.luu@vumc.org
Discharge Summary	Alisa Maloney	alisa.m.maloney@vumc.org
	Janie Linder	janie.e.linder@vumc.org
ED Provider Note	Linda Tibbs	linda.tibbs@vumc.org
	Maria Smith	maria.j.smith@vumc.org
Consultation Report	Maria Smith	maria.j.smith@vumc.org
	Linda Tibbs	linda.tibbs@vumc.org
Operative/Procedure Report	Cristie Hennis	cristie.hennis@vumc.org
	Steven Terry	steven.terry@vumc.org
Open Clinic Encounters	Danielle Osborne	danielle.m.osborne@vumc.org
	Yoshunnah Woods	yoshunnah.woods@vumc.org
Orders	Shayla Powell	shayla.powell@vumc.org
	Mae McLin	mae.mclin@vumc.org
	Rosaline Dozier	rosaline.dozier@vumc.org
	Tonya Johnson	tonya.johnson@vumc.org

Documentation Resources

Chart Corrections Resources

Chart Correction	Contact	Email Address
Epic Chart Corrections/Transcription	Susan Clark	susan.clark.1@vumc.org
	Joleen Barry	joleen.a.barry@vumc.org
	Holley Hess	holley.a.hess@vumc.org
	Sarina Henry	sarina.henry@vumc.org

Policy References

- Documentation Standards in the Medical Record
- Documentation Standards for Clinicians
- Provider Orders

Questions?

For questions regarding Record Completion documentation principles or policies, please email recordcompletionteam@vumc.org.

If you need assistance completing any Epic documentation workflows, please contact the customer care team: healthitprovidersupport@vumc.org