Clinician Documentation Standards — August 2021

WHAT YOU NEED TO KNOW:

VUMC requires that the responsible clinician accurately, concisely, and timely document the care, treatment, and services provided to the patient including the information gathered by the clinician during each patient encounter. Clinicians should attempt to complete all documentation at the conclusion of each encounter with the patient, and in no event can documentation be completed later than the defined time requirements set forth in this policy. Documentation not completed in accordance with established time requirements is considered delinquent. The medical record is not complete until all documents are finalized.

For a complete listing of relevant VUMC policies and additional resources, please refer to page 3 of this document.

Compliant Documentation
(See Documentation Standards in the Medical Record)
	• **Accurately reflects with attention to pertinent detail:**
	  ○ Severity of patient's illness;
	  ○ Risk associated with patient's illness and co-morbid conditions;
	  ○ Care, treatment, and services provided to patient; and
	  ○ Continuity of care.
	• **Is attested to or completed by Attending MD in a timely manner.**
	• **Captures "reportable diagnoses"**: conditions that coexist at time of admission or develop subsequently or affect patient care for the current hospital episode.
	  ○ Require clinical evaluation, therapeutic treatment, further diagnostic studies, procedures, or consultation;
	  ○ Extend length of stay; or
	  ○ Require increased nursing care and/or monitoring.

Definition of Clinician Roles	Clinicians play a critical role and are responsible to ensure the level of care provided to the patient, along with conditions that impact continuity of care, are documented in the medical record. As the saying goes, "If it wasn't documented, it did not happen."
Carry Forward/Cloning (See Carry Forward of Clinical Information in the Electronic Health Record and OHCC Guidance: Carry Forward (Cloned) Documentation)	Carry Forward/Cloning is a functionality that utilizes previously documented information to propagate text from one field to another part of patient's record. Encompasses variety of processes including Copy/Paste, Reuse, and Auto-Population (lab values, vital signs, allergies, meds, etc.). VUMC's EHR permits use of this function to assist with documentation efficiency. BUT, previously documented information imported, carried forward, or supplied by a template ***must be reviewed and edited to***: • **Remove all information that does not accurately reflect services provided** during and integral to the encounter being documented; and to • **Add any missing information** pertinent to the encounter, including time and conditions treated during the stay. **Important: It is a violation of the False Claims Act and NEVER permissible to copy information from one patient's chart to another or to take credit for services that you did not provide.** **Impact on VUMC and VUMC Clinicians:** • Valid, accurate, and updated documentation aids in continuity of care for patients and clinicians. • Compliant documentation reduces errors found with carry forward documents and eliminates note congestion. • Succinct and patient-specific notation helps provide justification when services/documentation are reviewed or audited.

Attestation and Signatures (See Documentation Standards for Providers and OHCC Guidance Documentation Menu Guide for Providers)	• **Attestation:** Signing of clinical document by Attending or Consulting MD signifying with verbiage (not merely a signature) that the document created by a member of the house staff represents evaluation, management, and care supervised and/or provided by Attending or Consulting MD. Typically represent a billable document.
	• **Signature:** Signing of document by Attending signifying that he/she reviewed the document created by Supervisee.
	  ○ Act of signing indicates Attending agrees with document content.
	  ○ Attending may or may not have been present at the time the evaluation, management, and care was provided.
	  ○ Unlike "Attestation" of a clinical note, **a simple signature does not typically represent a billable document for Attending.**
	• **Supervisee:** Individual involved in providing care who completes documentation in course of his/her training, professional practice, or on behalf of Attending (e.g., resident, professional staff with privileges).

Orders (See Provider Orders)	• Orders must be appropriately documented in the Legal Medical Record and authenticated in a timely manner by the ordering clinician. Verbal orders require authentication within 48 hours. • Verbal orders may only be given to qualified clinical staff acting within their scope of practice. Similarly, protocol orders may only be initiated by those same qualified staff members. • Clinicians should verify all verbal orders entered on their behalf are reviewed and authenticated promptly to ensure proper billing occurs for services rendered.
Timely Encounter (Documentation Standards for Providers)	Best practice is to complete documentation on the same day as the encounter. Per VUMC policy, clinicians may have longer to complete documentation before it is considered deficient or delinquent. BUT, they should not routinely complete records/documentation at the outside limit of **acceptable timeframes**: • Emergency Department Note: Within 24 hours or operations or procedure • Progress Note: At least daily • Consult Note: Within 24 hours • Operative/Procedural Note: Within 24 hours of procedure or surgery • Immediate Post Op Note: Immediately after procedure or operation and before patient moves to another area of care (out of PACU) • Inpatient Death Note: Pronouncement & document within 2 hours of notification (*Note: Discharge Summary also required) • Outpatient Encounter: Within 4 business days (outpatient encounter includes: intake screening & assessment, patient summary, clinic visit note, med rec, order, procedure note, or clinical summary) **Reminder: Documentation is considered delinquent if it is still incomplete more than 14 days from the encounter.**
Deficient/Delinquent Documentation (See Documentation Standards for Providers)	• **Best practice:** complete and sign all documentation on the same day service is provided. • **Deficient or Delinquent Documentation:** VUMC Documentation Policy requirements (e.g., missing elements of H&P, consult, clinical note, etc.) are not completed within the required timeframe. • **Deficient:** Documentation remains incomplete up to 14 days after date of discharge or encounter. • **Delinquent**: Documentation remains incomplete more than 14 days after date of discharge or encounter.
Consequences of Delinquent Documentation (See Documentation Standards for	Per Med Staff Bylaws, clinicians (excluding house staff) will be placed on Automatic Suspension of Privileges until delinquent documentation is completed.

Providers)	Suspension includes: • Inability to admit patients to any VUMC hospital; • Inability to schedule OR procedures; • Inability to submit claims for any professional services; and • Forfeiture of revenue associated with delinquent documentation deemed unsuitable for claims submission due to lack of content or timeliness of filing requirements/guidelines. FPPE will be initiated: • For Clinicians with 2+ automatic suspensions in 6 months; and • In the event an audit (either routine or for cause) discovers delinquent documentation. Note: Random audits occur regularly to assess compliance with documentation content requirements. • Detailed review of a clinician's documenting practices will occur when documentation is found not compliant with VUMC requirements.
Reporting Potential Concerns	• **Identify** the potential issue (no need to report every billing error to the Compliance Office, as routine claim adjustments happen daily). • **Report** the potential issue (the more information you can provide, the faster we can investigate and address issues found). o If you feel comfortable, report the issue to your supervisor and/or higher management in your area. If this is not the avenue you desire or if the issues are not resolved to your satisfaction, you can escalate to Compliance via: ▪ Direct Line: 615-343-7266 ▪ Direct e-mail: compliance.office@vanderbilt.edu ▪ Confidential Integrity Line: 1-866-783-2287 (24/7) ▪ Confidential web reporting (24/7) website • **Follow-up** on the report to help ensure corrective action was taken.

References

- Documentation Standards in the Medical Record
- Carry Forward of Clinical Information in the Electronic Health RecordCarry Forward of Clinical Information in the Electronic Health Record
- Provider Orders
- Carry Forward (Cloned) Documentation Guidance

Additional Resources

- OIG Compliance Guidance
- CMS website (Provider Focus) includes especially "Outreach and Education" Medicare Learning Network publications
- Guidelines for Teaching Physicians, Interns, and Residents
- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services (generally, but Physician Services at 30.2 – 30.3)
- Medicare Claims Processing Manual Chapter 12 – Physicians/Non-physician Practitioners (generally, but Teaching Physician Rules at 100.1-100.2)
- Clinician Guidance: Physicians and Advanced Practice Providers – Direct to Patient Telehealth
- Compliance Guidance - Telehealth