Title:	Medical Record Documentation and Completion - EMR	Page 1 of 3
Policy No:	1 MS 015	Effective Date: 11/01/2012

OBJECTIVE
To facilitate Medical Staff completion of medical record documentation, to specify timeframes for completion of medical records by the Medical Staff, and to outline the procedural steps that shall occur when medical records are not completed within the specified timeframe.

SCOPE
- All Medical Staff members
- All system-wide Health Information Management (HIM) Departments

POLICY
The provisions outlined by accrediting, regulatory, and licensing bodies, and Medical Staff Bylaws, Rules and Regulations, stipulate that all medical records, including observation, same day surgery, endoscopy, emergency room and inpatient records, shall be completed within 30 days of discharge. Medical Records entries shall be made according to the EMR physician order entry and documentation processes, at such sites that provide the EMR physician order entry and documentation processes and to the extent that said processes of the EMR are implemented. All other entries shall be entered in a form approved by the Medical Executive Committee (MEC), including downtime. Failure to comply with this policy will be construed as a violation of the DMC Medical Staff Bylaws Article XI § 2 (C), and subject to the actions under those provisions.

It is the responsibility of the physician assigned to specific deficiencies to complete them in a timely manner. All dictated documents must be authenticated. Records not completed within 30 days following the date of discharge will be considered delinquent. Any physician who has been on Automatic Suspension of Privileges for violation of this policy for a total of twenty six (26) weeks within a rolling fifty-two (52) week period shall be subject to further disciplinary actions. In order to meet these requirements and provide quality patient care, the DMC's Health Information Management Departments shall facilitate the process by notifying physicians of their medical records that require completion. Electronic documents shall be compatible with the Clinical Information System.

PROVISIONS
1. The following items represent the standards for the completion of the medical records and will be identified and tracked for completion by HIM Staff or other applicable departments:

    - History & Physical or Admission Note: Completion and authentication of a History and Physical is required; it may be included in an admission note. The medical history and physical examination (H&P) shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services.

    - A Discharge Summary must be completed and authenticated for inpatient records for all visits greater than 48 hours, for all complicated stays, and those in which patients have expired.

    - An authenticated Discharge Note is acceptable for uncomplicated inpatient records with a length of stay equal to or less than 48 hours.

    - A dictated or non-handwritten Operative Report must be completed and authenticated. The attending surgeon must authenticate Operative Reports completed by residents. An Operative Report is required for any procedure performed in an operating or special procedure room. The complete operative report shall be entered on the chart within seventy-two (72) hours following the procedure. The surgeon will be informed within twenty-four (24) hours of his failure to complete an operative report.

    - An Emergency Department Summary must be completed and authenticated for all Emergency Department encounters.

    - Consultations must be authenticated.

- If a query is necessary to clarify ambiguous or conflicting documentation in the medical record in order to facilitate complete, accurate, and consistent coding practices, the responsible physician will be notified via inbox, email and/or fax. Any chart awaiting a physician response will be included in the incomplete and delinquent record count until a response is received and documented in the medical record, or the physician responds that no addition or clarification to the record is necessary.

2. Physician notification of incomplete records is the responsibility of the Health Information Management Department or other applicable departments.

3. The Physician inbox of the Clinical Information System (CIS) will be the source of truth utilized by the Health Information Management Department for reporting medical record delinquencies.

4. Appropriate medical staff leadership will receive regular reports of attending or resident incomplete and delinquent record status from Health Information Management.

5. Each Health Information Management Department will provide the DMC Medical Record Committee (MRC) with information regarding medical record delinquencies. Medical record delinquencies will be measured at regular intervals, no less than every three months.

6. The MRC will review the delinquency information at each scheduled committee meeting.

7. If a physician is on the medical record suspension list 20 times (counted once each week) in a rolling 52 week period, the physician will be requested to appear at the Medical Staff Operations Committee or meet with the Chief of Department, Chief of Staff or Vice President of Medical Affairs to discuss plan for resolution of delinquent records. Upon completion of all delinquent records and if the physician then remains in compliance and off the medical record suspension list for four (4) consecutive weeks, the suspension count for rolling 52 week period will be re-initiated from zero. If the physician is on the medical record suspension list for an additional six weeks (26 times in total) they will be notified that they will be referred to the hospital peer review committee for further action which could include termination from the medical staff under the provisions of the voluntary resignation clause of the bylaws.

REFERENCES
DMC Medical Staff Bylaws, Rules and Regulations
Comprehensive Accreditation Manual for Hospitals
Vanguard Health Systems Policy PPCCOM008, 10/25/2010

ADMINISTRATIVE RESPONSIBILITY
- The DMC Executive Vice President Medical and Academic Affairs/CMO and the President of the Medical Staff or their designees have operational day-to day responsibility for this policy.

- Each of the Health Information Management Department Directors and other applicable Department Directors will be responsible for providing support to the Medical Staff leadership to assist with implementing this policy.

APPROVAL
This policy has been approved and is duly authorized by Detroit Medical Center, Children's Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

REVIEW DATE: November 2015
Revised JCC: 1.22.08; 6.23.09
Sponsor: Vice President, Health Information Management
DMC Medical Record Committee

Posted January, 2014

SUPERSEDES
1 MS 015 Medical Record Documentation and Completion – 07/01/2009
1 MS 015 Medical Record Documentation and Completion – 01/22/08
1 MS 015 Medical Record Documentation and Completion – 11/01/06
1 MS 015 Medical Record Documentation and Completion – 4/01/06
1 MS 015 Medical Record Documentation Requirements – 01/01/04; 01/01
1 MS 016 Medical Record Completion - January, 2001