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**I. SCOPE:**

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

**II. PURPOSE:**



The purposes of this policy are to ensure that chart completion at Tenet Hospitals fully and accurately reflects a patient’s care and is in accordance with federal, state, The Joint Commission (TJC) and Tenet requirements.

**III. DEFINITIONS:**

- A. **“Physician”** means, for the purposes of this policy, a physician or any licensed independent practitioner who is legally accountable for establishing the patient’s diagnosis.
- B. **“Surrogate Dictator”** means an individual or individuals who were not involved in the care or treatment of the patient but who dictate any portion of the medical record at the direction of the Physician. Surrogate Dictator does not include residents involved in the treatment of the patient or individuals serving as scribes during a patient’s treatment.

**IV. POLICY:**



Tenet Hospitals will utilize standardized Health Information Management (HIM) procedures for determining incomplete medical records, for determining when an incomplete medical record has reached a delinquent status, and for documentation requirements. Each hospital will include provisions for a suspension policy in its Medical/Professional Staff Bylaws/Rules and Regulations. Administration and/or Medical Staff Leadership at each hospital, in accordance with the policy approved by the hospital’s Medical Staff and Governing Board, will be responsible for uniformly enforcing the suspension policy for all individuals with delinquent medical records.

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## V. PROCEDURE:

### A. Hospital Chart Completion

1. The process utilized for calculating/counting incomplete medical records and determining delinquent status must comply with all applicable federal, state, TJC and Tenet requirements.
2. Tenet Hospitals will enforce the delinquency provisions of their Medical Staff Bylaws. Suspended individuals will have no privileges other than continuing care of patients already in the hospital and emergency admissions.
3. All types of treatment records except Emergency Department (ED) and outpatient diagnostic records shall be included in the medical record counting process (*e.g.*, inpatient discharges, including mothers and newborns, outpatient observation discharges, ambulatory surgeries, endoscopies and cardiac catheterizations). If ED records (*i.e.*, emergency records of patients who subsequently are not admitted to the hospital as inpatients or observation patients) are counted for the TJC reporting purposes, the ED records also must be analyzed for completeness. The numerator and denominator must consistently reflect delinquent charts and visits/discharges for the same patient types. The HIM Director is responsible for overseeing the accuracy and completeness of these processes.
4. Missing signatures cannot be excluded when counting incomplete and/or delinquent medical records.
5. Administration and/or the Medical Staff Leadership shall enforce the standards defined in this policy and shall immediately recommend disciplinary action for any non-employed clinicians or professional staff reporting false information related to the delinquent medical record/suspension policies of the hospital.
6. New employees/clinicians/professional staff shall receive orientation training on the chart completion policies and their responsibilities in meeting the requirements of those policies.

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7. The Director of HIM is responsible for ensuring that a procedure is in place in the HIM Department to determine incomplete medical record status.
8. The Director of HIM is responsible for ensuring that a procedure is in place to determine when an incomplete medical record has reached delinquent status; records reach delinquent status no later than 14 days after discharge for Tenet Hospitals located in California and no later than 30 days after discharge for all other Tenet Hospitals. The procedure must include a specific method for calculating the delinquency. Count the first day following discharge as day one of incomplete status, not the allocation day (the day the chart becomes available to the physician responsible for its completion). The procedure also must include a specified method for notifying the responsible party of his/her delinquency and for communicating to Administration and/or Medical Staff Leadership that the delinquencies are present. The notification to all parties shall occur in a uniform and timely manner.
9. Delinquent chart counts must be conducted at a minimum of once a month. If an automated chart management system is utilized in non-Horizon Patient Folder (HPF) HIM Departments for determining the delinquent chart count, the facility has a mechanism by which the accuracy of the delinquent chart count may be cross referenced and/or validated through various report functions.
10. A direct line of communication shall exist between the HIM Director and a designated individual in Administration (*i.e.*, CEO or COO) and/or Medical Staff Leadership regarding persons needing to be placed on suspension. All appropriate hospital departments shall be notified of those individuals placed on suspension.
11. With the exceptions of the authentication of verbal orders and Surrogate Dictators, as discussed in Subsections V.C.1. and V.B., respectively, no one, including Medical Staff members, shall be permitted or requested to complete a medical record when they have not participated in the care of that patient, regardless of the status of the practitioner who is responsible for completing the record.
12. Medical records shall not be permanently filed until completed by the responsible practitioner OR as ordered filed by the designated Medical Staff Committee and/or the Governing Board. An incomplete medical

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record will not ordinarily be filed as such if the practitioner is still a member of the medical staff or holds clinical privileges in the hospital. Each facility will establish a process for the administrative closure of records.

13. Practitioners who are removed from the Medical Staff pursuant to the Rules and Regulations for delinquent medical records OR who resign from the Medical Staff without adequately completing all medical records will not be allowed to return or reapply for staff privileges/membership until such records are satisfactorily completed.



#### B. Surrogate Dictation

1. Completing medical records is a requirement of the hospital's Medical/Professional Staff Bylaws/Rules and Regulations and of medical staff membership. No one, including Physicians, residents, physician assistants, or others, shall be separately compensated by the hospital for completing medical records. A Physician may compensate a third party for the provision of dictation services, provided the procedures set forth in this policy are followed.
2. When a Surrogate Dictator is utilized (this includes anyone who has not participated in the care and treatment of the patient), the individual must apply for and be granted privileges by the Medical Staff to perform this service.
3. The discharge summary must be signed by the attending Physician with a statement that indicates that the dictation is an accurate account of the patient's stay and includes all pertinent information.
4. The quality, accuracy and timeliness of reports dictated by a Surrogate Dictator must be reviewed as a part of the regular medical record review function by the appropriate Medical Staff committee and appropriate action taken if problems are identified.

#### C. Documentation Requirements

1. Verbal Orders

As required by the Hospital Conditions of Participation published by the Centers for Medicare and Medicaid Services (CMS), physicians may only

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authenticate their own chart entries.<sup>1</sup> CMS has issued an exception for verbal orders. The exception provides that verbal orders do not need to be signed by the prescribing practitioner, but could be authenticated by another practitioner responsible for the care of the patient. All verbal orders must be authenticated based upon federal and state law. If there is no state law that designates a specific timeframe for the authentication of verbal orders, then verbal orders must be authenticated within 48 hours.<sup>2</sup>

## 2. History and Physical

The medical record will not be considered complete unless it includes documentation that:

- a. a patient history and physical (H & P) was performed no more than 30 days prior to admission, and
- b. an update note, documented within 24 hours of admission or prior to surgery, that addresses any changes in the patient's medical condition since the H & P was conducted.

Note: This applies without regard to the purpose of the admission (*i.e.*, whether the patient is admitted for medical diagnosis or treatment, surgery, or any other type of procedure).

## 3. Discharge Summaries



All discharge summaries should include the following information: the reason for hospitalization; procedures performed; care, treatment, and services provided; patient's condition and disposition at discharge; information provided to the patient and family; and provisions for follow-up care.

## 4. Authentication/Autoauthentication

- a. It is the responsibility of the clinicians/staff members/individuals who make a chart entry, dictate a report for transcription or give a verbal order to authenticate that item within the medical record as defined by law or regulation. In no case shall entries be labeled as "dictated but not read." Each entry must be authenticated.

<sup>1</sup> 42 CFR §482.24

<sup>2</sup> 71 FR 68672 (November 27, 2006)

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b. Autoauthentication, whereby a physician signs one document to “authenticate” all missing signatures, is not acceptable. Each entry in the chart must be authenticated with the Physician’s signature and date of signature.

c. For imaging systems such as HPF, enabling any auto signature feature is prohibited.

5. Electronic Signature

Electronic signature keys may be used to authenticate medical records when permitted by state law and expressly permitted in the hospital’s Medical Staff Bylaws/Rules and Regulations. An electronic signature key may only be utilized by the Physician to whom it is assigned. Any Physician desiring to use an electronic signature for authentication must provide the hospital with a signed document that indicates he/she has a unique signature identifier and he/she is the only individual who uses it. The form must be maintained as part of the Physician’s Medical Staff credentials file.

6. Rubber Stamp Signatures



Rubber stamp signatures may not be utilized to complete any medical records as CMS does not accept rubber stamp signatures “as sufficient documentation to support a claim for payment.”<sup>3</sup>

7. Signature of Transcribed Reports

If a Surrogate Dictator dictates a report, the report must identify the person providing the dictation (e.g., “dictated by John Jones for William Smith, MD”). The Surrogate Dictator is not required to sign the transcribed report. However, the transcribed report must be signed by the attending Physician.

8. Progress Notes: Transcribed or Handwritten

<sup>3</sup>CMS Center for Medicaid and State Operations/Survey & Certification Group Memorandum to the State Survey Agency Directors, October 24, 2008

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Transcribed progress notes shall not be used in lieu of written progress notes unless strict turnaround times are stipulated in the Tenet Hospital's Medical Staff Bylaws/Rules and Regulations. If the mandated turnaround times cannot be met, the Physician must augment the medical record with legible handwritten progress notes. The Physician shall always make a written progress note entry indicating that "a progress note was dictated on this date." Any critical treatment information shall be part of this note even if the transcribed note is expected shortly. It is imperative that clinical staff treating the patient know the Physician's findings, recommendations, etc. The legibility of all chart entries is as critical to patient care as the timeliness.

9. Legibility

All entries in the medical record must be legible. Summary reports of illegibility data must be routinely submitted to the appropriate Medical Staff Committee.

10. Documentation Integrity; Late Entries and Corrections

- a. All entries should be made on the day of the occurrence or care episode; if information is recalled afterward, the late entry should be made as soon as possible after the day of occurrence/care.
- b. Handwritten late entries should be labeled "late entry." This may be entered in the same area of the chart (*e.g.*, same page) as original documentation, adequate space permitting, or entered on a blank form (same type as original documentation). The entry should be signed, dated and timed.
- c. Corrections and/or late entries to electronically stored patient information shall appropriately reflect the date/time of the entry, with corrections to any errors appropriately highlighted via available system mechanisms to alert clinicians to the updated/corrected information.
- d. Transcribed reports are considered finalized upon the author's authentication. Amendments to authenticated reports are accomplished via addendum. Both the original and addendum reports shall be maintained as a part of the medical record.

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e. Late entries made as corrections to previous handwritten documentation are accomplished as follows:

- (1) A single line is drawn through the error, without obliterating the original documentation. The use of “white out,” marker, scribbling or blocking out original information is unacceptable.
- (2) The corrected information is documented, complete with the author’s printed name, signature, title, and the current date and time.

f. Corrections to Incorrectly Affixed Patient Identification Labels

- (1) Prior to any correction of a patient ID label identified as applied to another patient’s record/document in error, the correct information shall be validated through at least one clinician involved with that patient’s care. As an alternative, the HIM Director may validate correctness of information based on clear indicators otherwise reflected on the document in question (*e.g.*, the correct patient’s handwritten name reflected on the mistakenly labeled document, other information that directly correlates to the patient’s record for confirmation, etc.).
- (2) Prior to initiating the correction, it must be established that the erroneous label did not adversely impact patient care. (To be determined in conjunction with hospital Risk Management; if patient care impact may have occurred, the label shall not be corrected, pending the outcome of any internal investigation and/or legal course of action.)
- (3) HIM staff may not assume correct patient identity based on documents arriving together post-discharge, physically within a same chart, otherwise bound/stapled together, etc. and affix a corrected label based on such assumptions.
- (4) Corrections determined as appropriate in these instances shall be made as follows:



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- (a) Upon verification as outlined above, the incorrect patient label should be removed from the document if this can be accomplished without damaging the page and/or adjacent documentation;
- (b) The correct patient label shall be affixed to the identified/correct patient document
- (c) If the incorrect patient label cannot be removed without damaging the document, the correct label shall be affixed over and effectively replace the incorrect/original label bearing another patient's personal health information.



#### D. Record Security

##### 1. Record Storage

Regardless of the state of completion of the medical record, each hospital is responsible for ensuring that all medical records are stored in a secure environment and that records and information are protected against loss, destruction, tampering, and unauthorized access or use. The records must be kept and maintained by the hospital that is the custodian of the medical records. The records must be maintained in an organized legible format that enables timely retrieval for patient care, auditing, or review purposes. This timely retrieval must apply to all patient care areas, including outpatient clinic treatment areas and other departments of the hospital. This requirement applies to records stored on site and off site. Storage of hard-copy medical records on site must be kept separate from non-clinical records (*i.e.*, human resources, business office) to ensure confidentiality and restricted access. Care shall be taken at all times to ensure that unauthorized individuals do not have access to medical records. Records shall be retained according to the schedules included in Administrative policy AD 1.11 Records Management.

##### 2. Record Receipt

Records of discharged patients should be received in the HIM Department within 24 hours of discharge. Records of Medicare patients from inpatient

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psychiatric and rehabilitation units are maintained on the discharging unit until the fourth day post discharge and are then sent to the HIM Department (see Regulatory Compliance policies COMP-RCC 4.32 Inpatient Rehabilitation Facility/Unit Medicare Interrupted Stay and COMP-RCC 4.51 Inpatient Psychiatric Facilities/Units – Medicare Interrupted Stay).

**E. Responsible Person**



The Director of HIM is responsible for ensuring that all individuals adhere to the requirements of this policy. If the Director is unable to create adherence to this policy, the Director shall immediately report the non-adherence to the Hospital Compliance Officer.

**F. Enforcement**

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

**VI. REFERENCES:**

- CMS Hospital Conditions of Participation: Medical staff
- CMS Hospital Conditions of Participation: Nursing services
- CMS Hospital Conditions of Participation: Medical record services
- Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations: Final Rule (71 FR 68672, November 27, 2006)

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- CMS Center for Medicaid and State Operations/Survey & Certification Group Memorandum to the State Survey Agency Directors, October 24, 2008
- The Joint Commission 2011 Information Management Standards
- The Joint Commission 2011 Provision of Care, Treatment, and Services Standards
- The Joint Commission 2011 Record of Care, Treatment and Services Standards
- Administrative policy AD 1.11 Records Management
- Regulatory Compliance policy COMP-RCC 4.32 Inpatient Rehabilitation Facility/Unit – Medicare Interrupted Stay
- Regulatory Compliance policy COMP-RCC 4.51 Inpatient Psychiatric Facilities/Units – Medicare Interrupted Stay