UC Riverside, School of Medicine Policies and Procedures
Policy Title: Medical Record Documentation and Completion
Policy Number: 950-03-020

Responsible Officer:	Chief Medical Officer
Responsible Office:	Clinical Affairs
Origination Date:	01/2022
Date of Revision:	04/2023
Scope:	Medical Record Documentation and Completion

I. Policy Summary

The purpose of this policy is to affirm UCR Health's commitment to ethical, complete, accurate, and consistent coding and documentation practices and to establish guidelines for the content, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in federal and state laws and regulations. The School of Medicine shall ensure appropriate and timely collection of patient encounter information for clinical services provided by SOM faculty at University owned and operated sites as well as clinical services that are provided at Affiliate Sites.

II. Definitions

Affiliate Site: A location where clinical services are provided, that is not owned or operated by UCR, but where UCR Health faculty are credentialed and approved to practice at through the University. Examples include acute care hospitals, skilled nursing facilities, and ambulatory surgery centers.

Medical Record: The collection of information concerning a patient and his or her health care that is created and maintained in the regular course of UCR Health business in accordance with UCR Health policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

III. Policy Text

A. Maintenance of the UCR Health Medical Record

1. A Medical Record shall be maintained for every individual who is evaluated or treated as a patient at UCR Health practice site.
2. The Medical Record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and may include patient identifiable source information, such as photographs, films, digital images, and monitor strips and/or a written or dictated summary or interpretation of findings.

B. Confidentiality

1. The Medical Record is confidential and is protected by law against unauthorized access, use and disclosure by law.

C. Content

1. Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnoses, establish medical necessity, justify the treatment, document the course and results, and promote continuity of care among health care providers. It is the

policy of UCR Health that medical records are maintained for every person treated and the medical record will be completed within 48 hours of when the care is provided.

2. All entries shall be accurately dated and timed. The medical record shall also contain evidence of appropriate informed consent for any procedure or treatment for which it is appropriate.

D. Timely Submission of Medical Records Data

1. Documentation for services furnished at Affiliate Sites, which may include additional patient encounter information, must be timely furnished to the applicable UCR Health office.

IV. Responsibilities

UCR Health clinical faculty and staff

V. Procedures

A. Core Content.

Documentation in the medical record shall include, but shall not be limited to, the following information:

1. Patient identification information: name, address, birth date, sex, next of kin, medical record number, legal status, name of any healthcare agent Patient's language and communication needs
2. Current medication and dosages
3. Known medication and food allergies and adverse drug reactions
4. Advance Directives, including designation of a healthcare agent, as appropriate (patients 18 years of age and older)
5. Informed consent as required by the place of service or nature of procedure
6. Documentation of patient encounters: Reason for care (chief complaint, reason for visit): The patient's initial diagnosis, diagnostic impression(s); Other medical conditions (problem list, health screening or assessment); Relevant patient history; Physical examination or mental status examination; Plan of care that includes treatment goals and revisions to the plan; Orders for tests, medications, procedures, consultations

B. Coding

1. All pertinent diagnoses, including complications which can be coded using ICD-10 coding must be documented.
2. All operative procedures, including invasive diagnostic procedures which can be coded using ICD-10 and/or CPT codes must be thoroughly documented.

C. Required Timeframes for Record Completion

1. All medical records in an outpatient medical office must be completed within 48 hours of patient encounter. Inpatient records will follow the affiliate facility's medical staff Bylaws and/or Rules and Regulations or policies governing medical records completion.

D. Ensuring Charge Capture for Services Provided at Affiliate Sites

1. **Sites with Electronic Charge Capture Systems Enabled**: At sites that have electronic charge capture systems in place (such as Medi-Mobile), UCR Health providers are required to input their charges on the day that the charges were incurred, or by the end of their shift if the shift covers more than one calendar day.

2. **Sites without Electronic Charge Capture Systems.** Faculty members providing clinical services at Affiliate Sites are individually responsible for ensuring that all patient encounter information is provided to the Revenue Cycle office as soon as possible. At a minimum, the following information must be submitted to Revenue Cycle at least monthly:
   - Patient Name
   - Site of Service
   - Patient Demographic Information
   - Insurance information
   - ICD Codes

E. Late Entries and Addendum:

1. If a “late entry” or “addendum” is required, electronically enter, write or dictate “late entry” or “addendum” and the actual date and time of entry with signature.

F. ENFORCEMENT, CORRECTIVE & DISCIPLINARY ACTIONS

1. UCR Health Medical Records will be subject to audits to ensure accuracy, timeliness of completion and proper coding. Audit results will be forwarded to the Chief Medical Officer and/or CEO of UCR Health.
2. Compliance with the above policy is monitored by UCR Health Compliance Department. Violations of any of the above policy will be reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with Human Resource / personnel policies. Faculty members must comply with the good standing criteria in order to engage in outside activity and successfully progress academically.

VI. Forms/Instructions

Not Applicable

VII. Related Information

950-02-002 Access to Electronic Medical Record
950-02-009 Access, Use and Disclosure of PHI.

VIII. Revision History

Not Applicable

Approval:

COMPLIANCE COMMITTEE (04/28/2023)

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