

	Policy Title	Clinical Documentation -- Timely Completion of Medical Record Entries
	Policy Number	3.07
	Department	Clinical Compliance
	Effective Date	April 1, 2002
	Last Reviewed	April 17, 2023
	Approved By	Clinical Compliance Committee
	Approval Date	June 8, 2023

Policy

Timely completion of medical record entries is mandated by hospital and physician organization rules. Billing of service charges cannot precede completion of the corresponding medical record entry. The best practice is to complete the note for a patient service concurrent with or immediately following the rendering of the service. Where workflows do not permit this to happen, the following record completion deadlines must be met.

Office Visits & Services – On the date of service, but no later than within two business days of the clinical encounter.

Outpatient Hospital Ambulatory and Clinic Visits – On the date of service, but no later than within two business days of the clinical encounter.

Emergency Department Visits – A note finalized by the author’s act of electronic signature authentication.

Inpatient Admission Note – Within 24 hours of the patient’s admission time.

Inpatient Hospital Visits – Same day completion required. A daily note by the attending of record is required.

Operative Reports – Dictation of the procedure is to be completed immediately following the procedure, but no more than one hour after completion of the case. The documentation may be in the form of a dictation or completion of an operative note within the electronic health record. For dictated documentation, transcription turn-around (including physician review and sign-off acceptance) is expected within 24 hours of dictation. Note: Sound-files of dictation are not retained.

Ancillary Services – Final report within 24 hours of the availability of source data.

Telehealth Services – Services provided via telehealth will assume the record completion deadline of the type of encounter that would have occurred absent the option for telehealth

Purpose

Medical record documentation by physicians and other practitioners is required for all services rendered. Timely completion of medical record entries is required to ensure patient safety and quality standards are met, that all services provided are supported by an appropriate medical record entry, and that unintentional information blocking does not occur.

Medical record documentation must adhere to established medical record policies including but not limited to New York Presbyterian Hospital (NYP) Bylaws, the Joint Commission Organization (JCO) requirements, NYP Graduate Medical Education Policies, and Center for Medicare and Medicaid Services (CMS) Physicians at Teaching Hospitals regulations.

Scope

The scope and applicability of this policy includes all Weill Cornell Medicine (WCM) physicians and practitioners with professional fee coding and billing responsibilities.

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Definitions

Procedure

An incomplete electronic note is defined as documentation entered into the system but not finalized with the author's official electronic signature and closing of the encounter.

A medical record encounter note/entry is considered finalized by the billing provider's act of authentication which is accomplished by their electronic signature and dating of the medical record note.

The Clinical Compliance and Privacy Office (CPO) monitors open encounters on a monthly basis and alerts Departmental compliance staff to delinquent medical record entries as of the third (3rd) day of each month, with the expectation that the Department will implement corrective action to resolve delinquencies. These delinquencies are also reported to the Clinical Compliance and Oversight Committee on a monthly basis.

The electronic health record system automatically closes all open encounters older than 180 days. Services that are closed automatically are not billable.

During the normal auditing processes of provider billing records, the CPO may identify that a medical record entry did not meet the required completion timeframes, and therefore may cite "untimely medical record completion" as an audit finding.

Compliance with this Policy

The Compliance Department will review on an annual basis and update this Policy as needed

Contact Information

References

Policy Approval

Version History

Original Policy: Electronic Medical Record Guidelines

Created: April 1, 2002

Revision 1: June 9, 2004

Revision 2: November 1, 2021

Current Version: Clinical Documentation--Timely Completion of Medical Record Entries

Extracted from original policy and updated: April 17, 2023

Date	Author	Revisions
		Initial draft completed. Original date of issue.