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## Tips for Preventing Common Documentation Errors

It is the policy of EVMS Health Services that all services rendered by a provider are completely and accurately documented in the patient's permanent medical record. The medical record should be complete and legible, utilizing widely accepted and recognized abbreviations and symbols.

The following tips are offered as a result of recent internal as well as external audits.

### General Guidelines

- All documentation must be dated and signed or authenticated by the individual providing the service and documenting. *Signatures must be legible.*
- Patient names and the date of service must be on each page of the record (front and back of forms).
- Care should be taken when using macros or copying and pasting documentation in the EHR.
  - Documentation should always be reviewed to ensure that the information within the note is not contradictory.
  - Documentation should be specific to the encounter.
- Each note documenting a service must "stand alone".
- The reason for the visit (chief complaint) must be documented.
- The teaching physician must personally document (following the teaching physician guidelines) in order to bill for an evaluation and management service.

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- The teaching physician must establish his/her presence and service to the patient by using “I” statements. For example, “I saw the patient...” or “I examined the patient...”
  - The teaching physician must “link” his/her documentation to the relevant resident documentation.
  - The status of chronic conditions must be documented. A list of diagnoses is not sufficient.
  - Only teaching physician time may be used to substantiate a charge.

#### **Guidelines for Specific Types of Service**

- Documentation of past, family and social history is required for levels 4 and 5 new patient visits (99204 and 99205), levels 2 and 3 initial inpatient (99222 and 99223) and observation (99219 and 99220) care. The use of “noncontributory” should be avoided.
- The lowest levels of initial hospital care (99221) and initial observation care (99218) require documentation of at least a detailed history and exam.
- Documentation of the request for an opinion must be present in the record in order to submit a charge for a consultation. Documentation that the opinion was sent to the requesting physician must also be present. *Note that Medicare no longer reimburses the consultation codes (99241-99245 and 99251-99255).*