HIM Frequently Asked Questions

Suspension Process

Why am I on suspension?
You have delinquent records – records which have not been completed in the time frame outlined in our governance documents and by state/federal regulations. All documents are considered delinquent if not completed by 7 days post discharge.

What is the timeframe for record completion?	Timeframe to complete	Considered delinquent*
Document type		
History and Physical	24 hours after the admit order time and prior to invasive procedure.	At the time of discharge (or earlier if found during concurrent review while the patient is still inpatient)
Operative Report/ Procedure Notes	Immediately following surgery	24 hours post op
Discharge Summary	**7** days after discharge	7 days after discharge

* Once a document is delinquent, you will be placed on suspension if the document is not completed as of the next suspension processing date (Tuesday at midnight).

What is the suspension process?

HIM analyzes charts both while a patient is in the hospital (concurrent review) and after discharge. As soon as a deficiency is found (for example, a missing operative note or procedure note), the provider is "assigned" the deficiency – meaning that notice is sent to the inbox indicating that the document needs to be dictated or signed. At any time, a provider can print a list of incomplete documents from the EXPLORER menu in oneChart. A provider is put on suspension on Wednesday morning if they have documents that are delinquent (past the acceptable timeframe for completion) as of Tuesday night at midnight. An inbox message is sent notifying the provider of the suspension.

What does" voluntarily relinquish your privileges" mean?

Your staff membership and all clinical privileges are removed immediately. You may not treat patients in the hospital. Once your privileges are relinquished, you will have to reapply for appointment to the medical staff (which includes payment of all applicable fees as well).

How do I get off of suspension?

Once you complete your delinquent records, you will be removed from suspension list. To be removed immediately – contact HIM. HIM will monitor the suspension list daily and remove physicians who have

completed delinquent charts. To be removed throughout the day contact HIM Physician Service Team: 901-516-8493 or 901-516-8368

Note: MHMH Rules & Regs require discharge summaries be COMPLETED (this means performed ***and*** signed) by 7 days after discharge. A suspension notice will be issued Wednesday morning to suspended physicians.

Avoid suspension:

Leave Time – Place Deficiencies on Hold for physician "time away" Physician(s) or office staff, for "time away" notify the Physician Service Team by phone, email, or inbox:

Phone	Email
901-516-8368 or 901-516-8493	PJ Hayes pj.hayes@mlh.org Jerika Gooden Jerika.cartergooden@mlh.org Clinton Nassar Clinton.nassar@mlh.org April Lechner april.lechner@mlh.org
	Inbox Message: System, HIM messaging

☐ Chart deficiency aging will stop on the first date of the leave time
☐ No suspension will occur while the physician is on leave time
☐ Chart aging resumes the day after the stop date but the chart aging is counted from discharge

What is the difference between a "deficient" and "delinquent" document?

Deficient simply means "incomplete". These are documents which have been assigned to you. Delinquent means "past due." These are documents which generate a suspension if not completed by the next suspension cycle (Tuesday night at midnight).

How does medical records suspension affect me?

While on suspension, you may not schedule any elective procedures, book same day surgery beds, or directly admit patients. Once you complete the delinquent records and notify HIM, they will remove the suspension, and you will be able to schedule your procedures.

MHMH Rules & Regs state that a medical record suspension rate of 50% or more for the past year will result in a shortened reappointment period. If a shortened reappointment is received, the medical record suspension rate during that shortened reappointment must be lower than 30%.

Who can I call if I think I was placed on suspension erroneously?

Contact your HIM department.

How does HIM determine which doctor is responsible for a document?

According to the Rules & Regs, the attending physician (as indicated on the admission order) is responsible for ensuring completion of the medical record. The attending is responsible for having the H&P available within 24 hours after admission & for a discharge summary being completed within 21 days post discharge. If a patient is seen on the first day of admission by a covering physician, the attending is still responsible for the H&P unless there is an HIM communication order stating that another physician is responsible for the H&P. If the patient is discharged by a covering physician, the assignment for the DC summary goes to the attending at the time of discharge unless there is an **HIM communication** order stating that another physician is responsible for the discharge summary. Operative reports are assigned to the primary surgeon. **Refused deficiencies will be reviewed for appropriate assignment. If HIM determines the correct attending physician has been assigned the deficiency will be added back to the encounter.**

Can I appeal my suspension?

Yes. Requests for review can be submitted to the **HIM Manager of Physician Suspension**, PJ Hayes. Information will be gathered from the various HIM departments for consideration.

How is my suspension percentage calculated?

Your suspension rate is calculated by the number of times you are suspended on Wednesday morning, not by the number of days you are on suspension or the number of charts for which you are suspended.

How can I tell what deficient (incomplete) documents have been assigned to me?

The oneChart Message Center Inbox shows incomplete charts. You can also view and print the incomplete document list at anytime using the EXPLORER menu. The report can be found in the Physician folder and is called "Deficiency by Physician Detail". Click in the Physician box and it will pull up a window where you can enter the physician's name. Type the name of the physician in the Accept box and hit "Query". The physicians name will appear in the "From Available" box. Click the arrow to move it to the "To Selected" box, then click ok. Now, the physician name should appear in the "Physician" window. Click "Execute". This is the same report HIM uses to determine which providers are placed on suspension each Wednesday morning. Please review this list weekly and notify HIM if you disagree with the assignments.

I've already dictated/signed a document, but it is showing in my inbox as incomplete. Why?

Our system is designed to automatically remove a deficiency once a document is completed. A dictated deficiency will remain in the inbox while it is being transcribed. This usually takes several days. Once transcribed, the assignment moves from dictate status to sign status. When entering Documents by Dynamic Doc or Power note select the assigned deficiency. If the deficiency is not picked during the document performance process notify HIM for removal of the outstanding deficiency. The most common reason a deficiency isn't removed from dictate status is that it was performed under the wrong FIN. The system will not know that a discharge summary performed using an outpatient FIN belongs to an inpatient stay. Occasionally there are glitches in the system and the deficiency remains despite the document being present under the correct FIN and signed by you. Notify HIM by calling or by refusing the deficiency in your inbox and choosing "Already dictated/signed" as the refusal reason. This alerts

HIM there is a problem. HIM monitors a report of all refused documents daily. They may contact you if they have questions about the refusal.

How can I tell what actions have been done to a document?

Hovering the mouse over the bottom frame of the document will change the arrow to a double set of horizontal lines. Holding down the left mouse button, drag the bottom edge of the frame up to show a new window frame. This frame contains information about all actions preformed on that document, including anyone who has modified or forwarded it.

History and Physicals

Why can't I handwrite my H&P?

MHMH Rules & Regs have required all inpatient H&Ps to be created in electronic format since 2007. H&Ps can be 1) dictated using our transcription service, or 2) typed into oneChart using, dynamic document or power note template or 3) uploaded from your office into the system using the portal.

How long will it take to get my H&P transcribed?

If the dictated H&P is not available after several hours, call transcription or the HIM Physician Service Team before re-dictating it. Do not re-dictate an H&P until you have confirmed with transcription or HIM that the dictation is truly not present.

What do I with the H&P once it's it is present on the chart?

Documents unsigned by an attending will be in the *Preliminary* status. Review the document either in the patient's electronic chart or in your inbox. To make changes or additions, right click and choose *modify*. Once you are satisfied with the document, sign it. If you are an attending, the document is now final and no more changes can be made to the body of the document. Addenda can be made by right clicking and choosing *modify.* Addenda to a final document will appear at the top of the report. If you are a resident, you cannot finalize the document. You will need to forward it to your attending for signature (not just for review). Residents should review, correct, sign and forward their documents within 48 hours. **AHP documents will finalize however, the document should be forwarded to your attending for review and co-signature.**

What elements are required in an H&P?

History
- Chief complaint/reason for admission
- History of present Illness
- Relevant past medical history*
- Relevant family history*
- Relevant social history*
- Relevant review of systems*

Physical (to include relevant findings and at a minimum the following):
• Heart
• Lungs
• Examination of the affected body system

Impression and/or documentation of medical decision-making
Plan of care
* If not present/documented, the physician has determined this element is not relevant or non-contributory.

Who can perform the H&P?

Physicians, Nurse Practitioners, and Physician Assistants credentialed as LIPs (licensed independent practitioners) can perform H&Ps for their supervising physicians. Physician-employed RNs who are authorized to render services may only perform histories for the supervising physician. **H&P should be forwarded to the attending for co-signature.**

Do I have to dictate an H&P for ambulatory surgery and observation patients?

No. For Ambulatory surgery patients, completion of the "Focused Physician Assessment Form" is acceptable. However, it must be completed on the day of the procedure. If you complete this document ahead of the planned procedure, you will have to provide an H&P update on the day of the procedure. For observation patients, the same form is currently allowed.

Why am I being asked to update an H&P I performed in my office?

Regulatory guidelines require that any H&P performed prior to the actual admit time be updated to ensure that there are no changes. The update can be added to the H&P by typing or dictating the update, indicated on the H&P update form, or included in a progress note.
The update needs to include:
• The date the original H&P was performed
• The current status, including any changes in the patient's status since the H&P was performed. If there are no changes, this should be noted.
• Updated physical exam, indicating any changes since H&P was performed. If there are no changes, this should be noted.

Since our encounters are grouped by FIN numbers, make sure that the original H&P you updated is pulled forward/copied/included in the current encounter.

Which H&Ps can be updated?

An H&P performed within 30 days prior to admission can be updated, removing the need to dictate a completely new H&P. One provider can update and use another provider's H&P; however, do not mistake this as acceptable for personal billing purposes. Since our encounters are grouped by FIN numbers, make sure that the original H&P you updated is pulled forward/copied/included in the current encounter.

How do I update an H&P?

There are several options for updating an H&P.
1) If the H&P being updated has the same FIN for the current admission, type the update on the H&P (using the right click and modify option). If using an H&P from a previous encounter, open the H&P right click and highlight the document. Then, copy the document (using control-C). Next, open a blank H&P and paste the other H&P (using control-V). Add an update giving any changes or indicating that there are no changes. Once satisfied with the document, sign it.
2) An update can also be dictated – indicate at the beginning of dictation that it is an H&P update and giving the date of the H&P you are updating. The transcriptionist will pull forward the old H&P into the new FIN and add your update. The document will appear in your inbox.
3) An H&P update form can be completed. You MUST include the date of the H&P you are updating. (As we move towards all electronic documentation, this form will be converted to an electronic document).

What is a Focused Physician Assessment form?

This is form is utilized for outpatient encounters which allows for paper documentation of H&P. There is an electronic version of the form available in the template section of one Chart. It is used for observation and ambulatory surgery patients. One exception – this

Do I have to* perform *an H&P for ambulatory surgery and observation patients?

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Why am I being asked to update an H&P I performed in my office?

The regulatory agency and Methodist R&R's require that any H&P performed prior to the actual admit time be updated to ensure that there are no changes. The update can be added to the H&P by typing or dictating the update, indicated on the H&P update form, or included in a progress note.
The update needs to include:
• The date the original H&P was performed
• The current status, including any changes in the patient's status since the H&P was performed. If there are no changes, this should be noted.
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3) An H&P update form can be completed. You MUST include the date of the H&P you are updating. (As we move towards all electronic documentation, this form will be converted to an electronic document).

What is a Focused Physician Assessment form?

This is form is utilized for outpatient encounters which allows for paper documentation of H&P and discharge information. It is used for observation and ambulatory surgery patients. One exception – this form can be used to quickly document a H&P in the event of an emergency surgery/procedure. However, inpatient admissions will still need a regular, dictated H&P completed within 24 hours after admission.

My patient needs emergency surgery. How do I document an H&P quickly when I don't have time to wait for a transcribed report?

You can document your findings on the Focused Physician Assessment form or as a progress note (labeled "Admission note"). Document a brief history and appropriate physical findings. A full electronic H&P is still required within 24 hours after admission.

Consults

Why can't I handwrite my consult?

Methodist Healthcare Memphis Hospitals Rules and Regulations have required all inpatient consults be created in electronic format since 2007.

How long will it take to get my* dictated *consult transcribed?

If your dictated consult is not available after several hours, call transcription or the HIM Physician Service Team. The document may have been sent to QA due to difficulty understanding, interference on the line, or Dictaphone malfunction. Do not re-dictate the consult until you have confirmed with transcription or HIM that the dictation is truly not present.

Incomplete documents will be in the *Preliminary* status. Review the document either in the patient's electronic chart or your inbox. To make changes or additions, right click and choose *modify*. Once you are satisfied with the document, sign it. The document is now final and no more changes can be made to the body of the document. Addendums can be made by right clicking and choosing *modify.* Addendums to a final document will appear at the top of the report.

Discharge Summaries

What are the acceptable forms of discharge summaries?

All inpatient encounters require an electronic discharge summary – even if the patient leaves against medical advice or expires. This can be dictated or typed, but must be in electronic format.
For observation and same day surgery patients, there are several options. You can certainly dictate or type a summary, but also have the option to simply include the required elements in the final progress note. There is a discharge instructions order set which will include the required elements and hopefully streamline the discharge process for outpatient encounters.

How long will it take for my discharge summary to be transcribed?

It is our goal to have 75% of discharge summaries transcribed within 48 hours. If a discharge summary is needed stat for a patient transfer, use work type 44, instead of 4.

What do I do once the discharge summary is–shows* in a preliminary status*?

Review the document in your inbox or in the patient's electronic chart. Changes/corrections/additions can be made by right-clicking and choosing modify. Once satisfied with the document, sign it. This finalizes the document and no further changes can be made. If any additions are made after it is final, they will be added as addenda.

What elements are required in a discharge summary?

1. Reason for admission
2. Significant findings
3. Procedures performed, care/treatment/services provided.
4. Final Diagnosis
5. Condition on discharge
6. Information provided to the patient and family
7. Disposition, follow-up care provision

Who can perform the discharge summary?

A physician, Nurse Practitioner, Physician Assistant, resident or an RN credentialed to dictate discharge summaries can perform discharge summaries.

I performed the discharge summary, but it is still showing as incomplete. Why?

Our system is designed to automatically remove a deficiency (incomplete chart assignment) once a document is completed. *While being transcribed*, a dictated document will still show as needing to be dictated in the inbox. Once transcribed, the deficiency should automatically be removed from the "dictate" inbox. The most common reason a deficiency isn't removed from the dictation folder is that the document was performed under the wrong FIN. The system will not know that a discharge summary performed using the outpatient FIN belongs to an inpatient stay. Occasionally there are glitches in the system and the deficiency remains despite the document being present under the correct FIN. Notify HIM by calling or by *refusing* the deficiency in your inbox and choosing "Already dictated/signed" as the refusal reason. HIM reviews all of the refused documents and dictation assignments daily and may contact you if they have questions.

I forgot to include the required elements of the discharge summary in my final progress note for my observation/SDS patient (or to complete the discharge section of the OB form). Now I am being asked to dictate a discharge summary. Why?

Late entries into the medical record (entries made post-discharge) must be provided in electronic format. Our system does not support adding paper documents to our completed electronic record. However, we are working on a discharge order set which will prompt the physician to enter the required elements and hopefully streamline this process.

Operative Reports

When are operative reports due?

Operative reports should be dictated or created online in the electronic medical record within 24 hours of the procedure or they will be considered delinquent. If still lacking, a suspension will be issued after post discharge chart analysis.

How does HIM monitor for completion of these operative reports?

Concurrent analysis will be conducted at each facility in the MLH system utilizing the daily surgery schedule to review encounters types that fit the operative report/procedure report criteria. The following encounter types will be reviewed for deficiency:

- In-patient surgeries
- Ambulatory surgeries
- Cardiac catheterization laboratory procedures
- Interventional radiology procedures
- Gastroenterology laboratory procedures

If the documentation is not completed in the allotted time, a deficiency will be assigned. Below are the deficiency assignments:

- "Dictate Operative Report"
- "Dictate Procedure Report"

The deficiency assignment will serve as notice to the physician that the documentation was not completed within required twenty-four (24) hours post surgery/procedure. During the next suspension cycle, the Suspension Coordinator will review the assigned deficiency. Upon review, it will be determined if the deficiency has been cleared or if the physician shall be suspended. Documents which are still pending transcription will not generate a suspension.

I did surgery Monday morning and discharged the patient Monday afternoon without dictating the operative report. I was assigned a delinquency on Tuesday morning. If I don't dictate this document by Tuesday night at midnight, will I be placed on suspension as of Wednesday morning?

Yes.

Incomplete-documents will be in the *Preliminary* status. Review the document either in the patient's electronic chart or your inbox. To make changes or additions, right click and choose *modify*. Once you are satisfied with the document, sign it. The document is now final and no more changes can be made to the body of the document. Addendums can be made by right clicking and choosing *modify.* Addendums to a final document will appear at the top of the report.

What is required for an Ambulatory Surgery Record or Observation Encounter Stay 48Hours or less

A. An initial physician order for observation or ambulatory surgery should be entered: "Initial outpatient status order"
B. History and physical is required.
    a. Focused Assessment Form may be used for Ambulatory surgery encounters.
C. A final progress note or physician order titled Discharge per Same Day Criteria or Discharge Same Day Patient is acceptable in lieu of a discharge summary. In case of a patient's death a discharge summary is required.
D. If the patient is subsequently admitted to inpatient status, the reason for admission must be recorded in the progress note section and an electronic History and Physical is required.