Documentation Integrity Policy

Policy Number: 1234

I. POLICY

It is the policy of this organization to ensure that the protected health records of individual served is maintains in a manner that is consistent with the legal requirements and that all documentation is current, standardized, detailed, organized, and available to practitioners at each encounter, facilitates coordination and continuity of care, and permits effective, timely, quality review care and service.

II. PURPOSE

To establish guidelines for the contents, maintenance, and integrity of individual documentation in order to meet the requirements set forth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the health care record of service and supports delivered.

III. DEFINITION

None

IV. STANDARDS & PROCEDURES

1. Confidentiality: All employees having access to protected health records must sign the organizations confidentiality statement. Health Information may not be disclosed without the consent of the individual and/or their guardian. All individuals and/or their guardians are afforded the opportunity to consent to or deny the release of identifiable medical or other information except as required by law. Each individual record will be filed, stored, restricted from public access, utilizing standardized and centralized network tracking system. This system will assure ease of retrieval, availability and accessibility as well as confidentiality of the individual protected health record. All individuals will have the ability to review, inspect and/or obtain a copy of their Protected Health Information in their Health Record.

2. Information Governance: This organization will manage information as an asset and adopt proactive decision making and oversight through information asset management and information governance to achieve data trustworthiness and to avoid erroneous, incomplete, redundant, or untrustworthy data and records.

    a. Template Documentation: templates will play an important role in improving the efficiency of data collection, ensuring all relevant elements are collected in a structured format. The following standards will govern template documentation design;

        i. Templates may not exist for a specific problem or visit type. The structure of the note must be a good clinical fit and must accurately reflect the clients condition and services;

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ii. Templates will include options to document multiple problems or extensive interventions; and
iii. While templates will be designed to meet reimbursement criteria and to streamline documentation, they will include options to assure all relevant clinical information is captured to support the reasonable and necessary delivery of care.

3. Cloning & Copy/Paste Practices: the organization will adopt departmental procedures to assure compliance related limitations applicable to "copy and paste" functionality and documentation within an electronic health record. These procedures should be construed as applying to any feature which allows a provider to document a series of typed characters or other keystrokes in order to quickly document portions of a service and/or progress note.

4. Client Identification: all documentation will identify the client including name, date of birth, and record number. The organization will adopt identity integrity controls to assure that key demographic data on forms are accurate and used to link records within and across systems.

5. Authorship Integrity: Authorship attributes the origin or creation of a particular record of information to a specific individual or entity acting at a particular time. When there are multiple authors or contributors to a document, all signatures will be retained so that each individual's contribution is unambiguously identified.

6. Amendment Integrity: Addendums, corrections, deletions, and amendments will be included in the record as defined by federal HIPAA laws. In order to support the integrity of the health record, the organization will allow providers to make amendments, have the ability to track corrections, and identify that an original entry has been changed. Procedures will be implemented that outline when changes need to be made, what changes can be made, who can make the changes, and how these changes will be tracked and monitored.

7. Audit Integrity: Audits are essential for ensuring that the health record documentation present supports the level of service reported, that all payer requirements for reimbursement are met, and that only authorized users are accessing or making entries to client records. Internal Audit is responsible for examining and evaluating the adequacy and effectiveness of these controls.

1. Violations: Knowledge of any violations of this policy should be reported to the organizations Compliance Officer.

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