

RHC Documentation Requirements

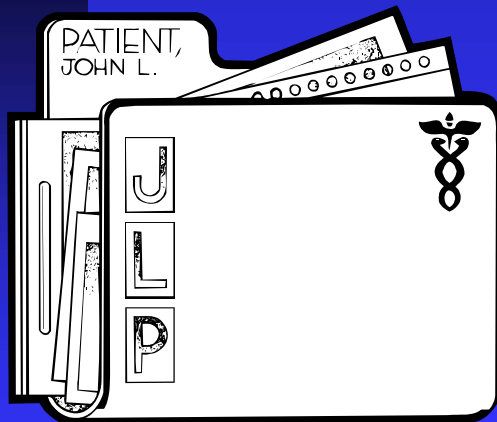
Presented by: **BethAnn Perkins, RN**

Health Business Strategies, LLC

1137 De Groff Street

Grand Ledge, MI 48837

517.627.7841 ♦ baperkins@comcast.net



RHC Visit Definition

- RHC “visits” are defined by Medicare as a face to face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinic psychologist, or clinic social worker during

RHC Visit Definition (cont.)

which an RHC/FQHC service is rendered. RHC services are limited to physician/extender services, services incident to those physician /extender services and (under limited circumstances) visiting nurse services. Physician/extender services are further defined as those professional services performed by a physician for a patient including diagnosis, therapy, surgery, and consultation, thereby codifying the distinction between a visit and a non-visit incidental service.

Face to Face Encounter

- Requires direct interaction between the practitioner and the patient for the purpose of providing evaluation and management services at a skill level that required the assessment, clinic reasoning, and judgment of a qualified RHC practitioner. The condition of the patient must warrant the specialized skills of the qualified RHC practitioner.

Face to Face Encounter (cont.)

- An encounter between a clinic patient and a physician, PA, NP, nurse midwife or (for visiting nurse services) a visiting nurse. Clinical psychologist and social worker encounters are visits in an FQHC environment and an RHC setting. Podiatrists, optometrists, dentists and chiropractors are physicians for certain procedures; however they are not licensed to provide general medical care.

Face to Face (cont.)

- An encounter with a podiatrist, optometrist, dentist or chiropractor MAY constitute a valid face to face visit if the provider is acting within the limits of his specialty and no other coverage and medical necessity restrictions apply. However they are not able to supervise physician extenders in the provision of RHC services, nor do they qualify as physicians for the purpose of determining physician coverage (i.e. an MD or DO must be present to consider the hours “physician covered”).

RHC Program Documentation Requirements 491.10(a)(3)

- For each patient receiving health care services, the clinic maintains a record that includes, as applicable:
 - (i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition and instructions to the patient.

- 491.10(a)(3)(ii) – Reports of physical examinations, diagnostic and laboratory test results and consultative findings.
- 491.10(a)(3)(iii) – All physician's orders, reports of treatments and medications and other pertinent information necessary to monitor the patient's progress.
- 491.10(a)(3)(iii) – Signatures of the physician and other health care professional

RHC Interpretative Guidelines

- Examine a randomly selected sample of health records to determine if appropriate information, as related in 491.10(a)(3), is included. This listing is the minimum requirement for record maintenance.

RHC Program Medical Record Management Requirements

- 491.10(a) – *Records system*
 - (1) The clinic or center maintains a clinical record system in accordance with written policies and procedures.
 - (2) A designated member of the professional staff is responsible for maintaining the records and for insuring that they are completely and accurately documented, readily accessible and systematically organized.

■ 491.10(b) – *Protection of record information*

- (1) The clinic or center maintains the confidentiality of record information and provides safeguards against loss, destruction or unauthorized use.
- (2) Written policies and procedures govern the use and removal of records from the clinic or center and the conditions for release of information.

(3) The patient's written consent is required for release of information not authorized to be released without such consent.

- 491.10(c) – *Retention of records*

The records are retained for at least 6 years from date of last entry, and longer if required by State statute.

LMRP – Medical Record Identification

- Each page of the medical record must be assignable to a specific patient by some form of identification, either a complete patient name or a unique medical record number. (Riverbend's interpretation of 491.10(a)(3)(i))
- Each face to face encounter documented in the medical record must include the date on which the encounter occurred or in the case of multiple visits on a single day, the date and time of the visits. (Riverbend's interpretation of the Social Security Act 1833(e))

LMRP – Signature Requirements

- **The provider signature may be appended to the medical record in any of several formats, but in all cases must be sufficiently unique to allow both the provider and Riverbend to determine unequivocally at a later date that the provider personally affixed the signature.**
- **The signature should ideally be legible but must at the minimum be ideographic (a consistently reproducible and unique autograph). A full name (e.g. John Smith) or a last name and credentials (e.g. Smith MD) are necessary for the signature to stand alone.**

LMRP – Signature Requirements

- If the signature services to authenticate a typed, stamped, dictated, computer-generated signature or third-party signature, it must still be sufficiently unique to unequivocally identify the author. Printed initials are inadequate for that purpose; a last name or script initials is usually the minimum appropriate validation.
- If credentials are not appended to the signature, the credentials associated with the signature must be apparent elsewhere in the documentation.

LMRP – Handwritten Entry

- Since the entry itself is ideographic, the signature need only include enough legible information to identify the provider. A last name is generally sufficient. If the facility wishes to keep a “signature registry” of its provider (a page with signatures and typed or printed entries identifying the owners of the autographs), it can provide a copy of the appropriate entry with any requested records in order to allow the decoding of illegible ideographs.

LMRP – Dictated Entry

- A dictated (typed signature) must be countersigned (an ideographic validation as detailed above) by the provider who performed the face to face, confirming that the provider has reviewed the dictation and verified that it was correct.

LMRP – Stamped Signature

- A stamped signature is acceptable as long as the facility has implemented procedures which clearly establish ownership and control over the access to the stamp.
- The physicians/extenders must be able to affirm that the stamp is available to them alone and that sufficient controls exist such that the stamped signature can be identified as being personally affixed by the provider and therefore equivalent to an inked autograph.
- A single affirmation should be kept on the file at the facility.

LMRP – Computer Generated

- Computer generated paper records are analogous to dictations. The typed signature must be countersigned by the provider who performed the face to face, confirming that provider has reviewed the computer generated record and verified that it was correct.

LMRP – EMR/EHR

- Purely electronic records are those that are stored electronically and printed only when documentation is needed by a third party such as Riverbend.
- An affirmation from each physician/extender that entries are password protected and ONLY the provider has access to must be kept on file

Legal Expectations of Medical Record Documentation

- All findings that are essential to a diagnosis or patient care;
- All findings (positive or negative) that are customarily documented in similar situations;
- Records should be consistent; and
- Continuous processes that are unchanged need not be documented.

Legal Expectations – (cont.)

- The description of an examination should clearly identify what was examined;
- Document the possible diagnoses/complications that are being considered; and
- All boxes, blanks or checklist on medical record forms should be completed.

Legal Expectations (cont.)

- Document medical complications, mishaps or unusual occurrences in the medical record;
- Use terms that reasonably reflect what happened and do not misrepresent the facts;
- Avoid expressions that imply disapproval or a negative value judgment of the patient;

Legal Expectations (cont.)

- Avoid expressions that imply the patient's complaints are not being heard or taken seriously;
- Describe your assumptions about the patient's motives as possibilities rather than as statements of fact; and
- Do not document your frustration with or disapproval of difficult patients.

If it wasn't documented . . .

Problems

- Illegible documentation
- Inadequate documentation that does not support the visit level billed
- Missing documentation, e.g., diagnostic reports, phone notes, Rx refills
- Documentation that does not meet RHC Program requirements

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"MS. DALY, HAVE THERE BEEN ANY IMPORTANT
E-MAILS OR VOICE-MAILS DURING MY INCARCERATION?"