A) Policy Statement

The Health Information Management (HIM) Department will be responsible for evaluating medical records of Inpatient, Outpatient Surgery, Basic Outpatient Procedure, and Observation patient types for specific documentation and signature requirements as specified in Medical Staff policy 3364-87-42 Documentation Standards.

HIM Analysis personnel will be responsible for evaluating charts for missing documentation or authentication, and the assigning of unlinked dictation deficiencies to the appropriate physician. As well as correcting unlinked deficiencies as necessary.

B) Purpose of Policy

To ensure that medical record documentation is complete and meets regulatory agency requirements.

C) Procedure

The legal medical record will be reviewed by HIM Analysis personnel and deficiencies will be assigned to the appropriate healthcare providers(s) in accordance in Medical Staff policy 3364-87-42 Documentation Standards.

Approved by:

/s/ Pamela Eaton
Director, Health Information Management
03/30/2020

/s/ Dan Barbee, MBA, BSN, RN, FACHE
Chief Executive Officer
03/30/2020

Review/Revision Completed By:
Health Information Management

Next Review Date 3/1/2023

Policies Superseded by This Policy: 10-240

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.