CU MEDICINE Requirement for Physician Timely Documentation

This guideline was written/approved by John A. Sbarbaro, MD, MPH, Medical Director of CU MEDICINE on September 16, 2003.

To date CU MEDICINE has had no policy standardizing the timeliness of physician documentation of patient care services.

Consultants and billing professionals have advised us that when a provider documents their involvement with a patient later than 24 hours from the date of service, the provider is not be able to recall all of the service that was performed and charges can be lost. There are also malpractice implications if essential findings or recommendations to the patient are not documented.

COPIC, the leading malpractice coverage company states that documentation should be completed within a 24-hour period. This is their expectation when, as part of their contracts with the state and federal government, they review medical records for supporting documentation and quality of care assurance.

To meet this expectation, I request that the Board of CU MEDICINE establish a policy requiring all members of CU MEDICINE to meet a 24-hour guideline for documentation.

Simply stated:

> All members of CU MEDICINE are to either dictate, type, or hand-write their documentation of any/all patient care services within 24 hours.

The exception to this guideline would be an ancillary department such as Pathology, whose physicians would be required to complete their documentation within 24 hours from the time of receipt of test results or prepared tissue slides.