Documentation

by Capella Healthcare

WHAT'S COVERED

In this lesson, you will learn about documentation standards and requirements. Specifically, this lesson will cover:

1. Documentation Needs
2. Record Content: Standards or Requirements

1. Documentation Needs

Telemedicine records should be kept in the same manner as other health records. The specific documentation needs vary based on the level of telehealth interaction.

The organization using telehealth information to make decisions on the patient's treatment must comply with all standards, including:

- The need for assessment
- Informed consent
- Documentation of the event
- Authentication of EMR entries

It must meet with all institutional policies and regulations for the privacy and security of PHI.

2. Record Content: Standards or Requirements

According to AHIMA's "Telemedicine Services and the Health Record" Practice Brief, the process for a telemedicine encounter may vary from organization to organization. However, there are some basic guidelines for the telemedicine encounter and documentation requirements.

1. The telemedicine provider must assess the patient's need for telemedicine services/orders through an identification assessment process.
2. Once the need is confirmed, a telemedicine appointment can be scheduled and executed.
3. The telemedicine provider is responsible for accurately documenting all required content during the telemedicine encounter.

4. The telemedicine provider completes the telemedicine encounter and will review telemedicine orders.
5. The telemedicine provider will incorporate telemedicine orders into the treatment plan.
6. Documentation of all steps and follow-up is required.

At a minimum, AHIMA recommends that each telemedicine record contain the following:

- Patient name
- Identification number
- Date of service
- Referring physician
- Consulting physician
- Provider organization
- Provider location
- Patient location
- Telemedicine order
- Type of evaluation performed
- Informed consent, if appropriate (In many telemedicine programs, the referring physician/organization retains the original and a copy is sent to the consulting physician/organization.)
- Evaluation results (In many telemedicine programs, the consulting physician/organization retains the original and a copy is sent to the referring physician/organization.)
- Diagnosis/impression
- Recommendations for further treatment

Additionally, the American Society for Healthcare Risk Management recommends the health record contain diagnostic test results, clinical evaluations, and instruction related to telehealth technology. Documentation should also reflect all clinicians involved in the telehealth visit as well as store-and-forward technology.
If a provider is at the originating site (hospital) and another provider is at a distant site (rural clinic), both should be documented in the medical record. The distant-site provider probably will not have access to the originating-site EHR for patient documentation purposes. Processes should be established in advance to ensure the distant-site documentation is not overlooked. The distant-site provider may request a copy of the informed consent.

Telehealth forms, policies, and procedures should be mutually agreed upon by health information management and legal counsel, ensuring processes for access, maintenance, and protection of records related to telehealth services are compliant with rules and laws governing health information and medical records.

To learn more about further documentation requirements for reimbursement, visit**CMS website**.

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Support

If you are struggling with a concept or terminology in the course, you may contact **TelehealthSupport@capella.edu** for assistance.

If you are having technical issues, please contact **learningcoach@sophia.org**.