Northern Light Health | Optum

From the Office of Health Informatics

Timely Documentation Manager Guide

Tuesday, February 18, 2025

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Timely Practitioner Documentation Policy (11-003) was reactivated October 16, 2024 and requires Managers/Leaders review and escalation of Documentation Tracker Report.

https://emhs.ellucid.com/documents/view/23327

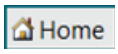
The Documentation Tracker Report is a snapshot in time so some items reflected may already have been completed by the provider once managers receive the report. The manager's responsibility is to review and verify for those still outstanding prior to speaking/giving to the provider for completion.

If it is not clear what is missing (so research assistance is needed) or if a provider needs to be updated, send an email message to NorthernLightRevCycleHIMReports@northernlight.org or use the Documentation Tracker Feedback Request in ServiceNow.

Ambulatory Organizer – Open Items

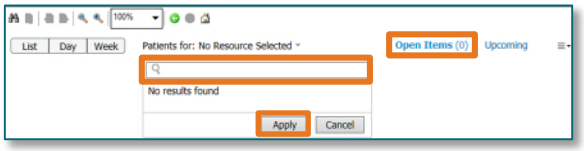
Open items display unfinished tasks for a patient's visit for the resource(s) selected. If more than one resource is selected, each provider's open items will display on a separate tab. Open Item tasks will display the appointments in sections of Today, Yesterday, 2 days ago, and More than 2 days ago.

➢ **Set up Open Items for providers overseeing.**

STEP 1: Select **Home** icon. 

STEP 2: Select **Open Items**.

STEP 3: Enter provider(s) name. All providers needed can be entered and will appear on separate tabs.

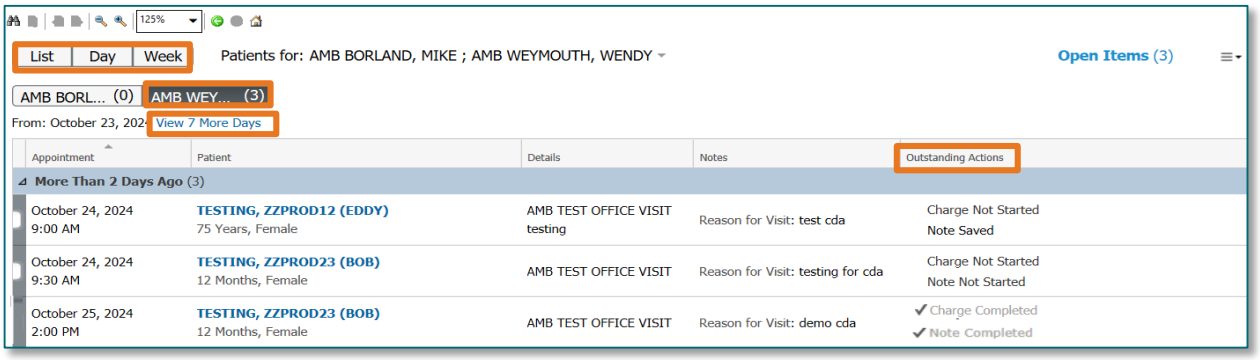


STEP 4: Select **Apply**.

STEP 5: Select the provider's **Open Items** tab to review **Outstanding Actions**.

- Charges for Visit
  - Charges Not Started – Charge not entered on this encounter/FIN.
  - Charges Completed – Charge placed on this encounter/FIN.
- Documentation for visit
  - Note Not Started – Dynamic Documentation note was not opened/started.
  - Note Saved – Dynamic Documentation note was opened and saved to complete later.
  - Note Completed – Dynamic Documentation note has been signed on the encounter/FIN.

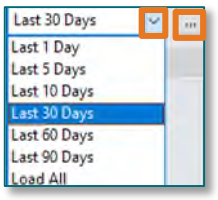
NOTE: To get back to the schedule view for provider(s), select List, Day, or Week.



NOTE: Display shows for 7days. To look back further, click the View 7 More Days link, this will continuously move 7 days at a time with each click.

Message Center Review

Proxies can be granted by the provider or managers can manually assign Message Center proxy. This allows ability to see/review items in a provider's Message Center based on lookback range.



➢ **Display**

- There are several options in the **Display**: dropdown menu, click to change lookback range.

  Click here for flyer on manager/provider assigning and taking proxy.

  Click here for flyer on granting proxy to personal message center.

NOTE: **Use the ellipsis button to the right of the Display dropdown field and use the calendar to set the lookback time to whatever is needed for pulling the oldest document in question. 'Load All' does not always pull everything.**

➢ **Inbox Items**

- **Documents**
  - Contains transcribed and/or scanned documents for signature, co-signature, or documents to review.
    - **Forwarded Documents to Sign** contains documents requiring a signature from a supervising physician.
    - **Forwarded Documents to Review** contains documents for review only.
- **Messages**
  - Contains communication regarding the patient.
    - **Coding queries** will appear in the provider's Message Center under **General Messages**.

➢ **Work Items**

- **Saved Documents**
  - Contains saved documents to **finalize** and **sign**. (Preliminary)
- **Documents to Dictate**
  - Contains notices sent by automation of missing documentation for certain note types to provider associated in Attending Provider registration field if one is not present. HIM manually adds only if they need to alter or update it after the deficiency has posted or per request.

- Notice sent to this folder means only that a note is missing. The note may be completed using appropriate method (e.g., dictation, dynamic document)
- When a **Documents to Dictate** notice is received, check **Saved Documents** folder before starting a new note from scratch.

NOTE: **Reach out to HIM at NorthernLightRevCycleHIMReports@northernlight.org if a provider should not have received the deficiency to have removed or reassigned.**

Workflow MPage (Adding/Customizing)

STEP 1: Open patient chart.

STEP 2: Select **Ambulatory View** on Table of Contents Menu.

NOTE: **Right-click the Ambulatory View in the table of contents menu to set as default view if preferred.**

STEP 3: Select **Amb Nursing 2018** MPage, add if not visible.

- Select the **Add MPage** icon.
- Search and select the **AMB Nursing 2018 MPage**.

STEP 4: Customize the component layout by using drag and drop.

Locating/Reviewing Documentation Notes

➢ **Completely Missing**

- Provider documentation note will **not** be seen for that DOS under Completed in documents component.

➢ **Not Signed – Preliminary**

- Provider documentation will show under **In Progress** in documents component.

NOTE: **These will also be in the provider's Message Center inbox under saved documents.**

➢ **Wrong DOS/Wrong FIN/Wrong Note Type**

- Provider documentation note found in chart with wrong DOS/FIN/Document Type will not satisfy as completed on ambulatory organizer.

STEP 1: Click **Provider Documentation**.

- New window opens.

STEP 2: Click **View Document**.

STEP 3: Review Result Type, Service Date, and Encounter Information for accuracy. Reference the banner bar for the DOS, Encounter/FIN, Location.

NOTE: **If searching a patient, be sure to select the correct DOS encounter for the visit date for the appropriate information to display in the banner bar. If opening from Ambulatory Organizer, the correct encounter will display.**

- Result Type
  - Reflect appropriate document type for visit. (e.g.: Primary Care Office Note, Discharge Summary, etc.)
    - Medical Student Note needs to be updated by the signing provider and not left as Medical Student Note, this type will not satisfy.

  Click here for flyer on Dynamic Documentation Med Student.

  Click here for flyer on Documenting a Nurse/MA Only Visit.

NOTE: **If a document is scanned with a satisfying document type on the encounter, this will appear as satisfied on the Ambulatory Organizer for the provider.**

NOTE: **When scanning records on ambulatory encounters, a 90 day look back date should be used and never future encounters. In the event there is not an encounter within the 90 days look back, a non-billable encounter should be created.**

Click here for creating non-billable encounters for Legacy locations.

Click here for creating non-billable encounters for Maine Coast.

- Service Date
  - Must reflect the Date of Service (DOS) the visit was scheduled/patient seen.
  - Click here for flyer on Changing the Date of Service. This workflow can be used to change the Document Type as well.
- Encounter info.
  - Contains the FIN, Location name, encounter type (e.g.: ambulatory, inpatient, etc.), and date of visit/admission and discharge date.
  - Click here for flyer on Dynamic Documentation FIN Correction.

Incomplete Note/Query Response Needed

- **Incomplete Note**
  - When the primary report was complete, there was incomplete information requiring additional documentation (e.g.: missing procedure details).
- **Query Response Needed**
  - Outpatient Queries will be sent to the provider's inbox within Message Center.
    - Provider should address/addend the note and respond to the query letting the coder know it has been completed.
      - If sent in Message Center, a copy of the query should be visible in the patient chart.
        - **Notes > Clinical Documents >Administrative >Not Part of Legal Medical Record >Coding Query Note**.

    For information regarding the outpatient queries, please contact **#NLH HIM Coding Leads-Outpatient** via email.
  - Inpatient Queries will be sent through Fluency Direct using CDI Engage Workflow.
    - Inpatient Nudges: This is an auto generated "nudge" based on clinical indicators in the record. This is delivered to inpatient providers through MModal/Fluency Direct.
    - Inpatient Queries: These queries are manually generated by the CDI Staff and/or Coding Staff and sent to providers via 3M 360 to MModal/Fluency Direct.
      - Provider should address. Click here for a CDI Engage One Pocket Guide.

    For information regarding the inpatient queries, please contact **#NLH Coding Inpatient Leads** via email.
  - External Provider Queries.
    - Inpatient side (examples Residency Program, NICU, Downeast Ortho, Downeast OB/GYN) go via email to manager and practitioner, as they do not have access to view Fluency Bar/MModal.
    - Outpatient happens very seldom. The supervisor faxes to provider private office.

No Show/Patient Left without being Seen

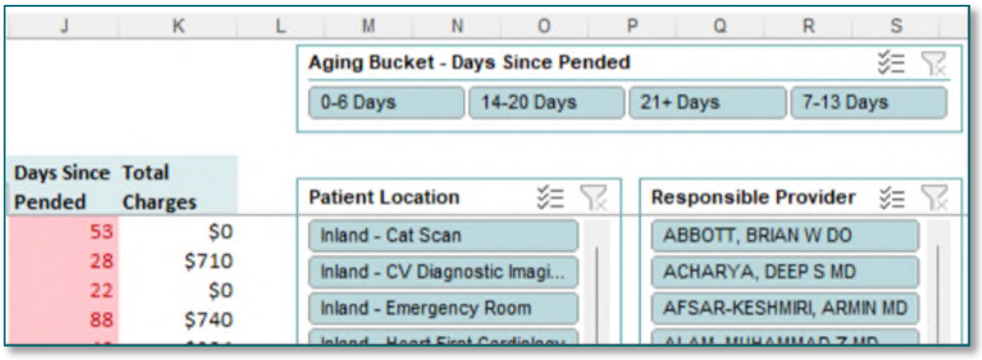
- **Patient leaves without being seen and has no documentation entered on chart.**
  - The Encounter/FIN needs to be cancelled unless they can be rescheduled on the same day at a different time.

    Click here for Reschedule, Cancellation & No-Show Workflow.

- **Patient leaves without being seen and has some documentation entered, ex: vitals, labs drawn/completed.**
  - Document the patient left without being seen and leave encounter so the appropriate charges can be coded from the reason the patient presented for any documentation entered and/or testing done/completed on the Encounter/FIN.
    - Coding will be looking for a statement by clinical staff or provider stating patient left without being seen and includes what had been done. Ex: patient roomed and vitals taken and left before being seen by the provider. If left on an office note or free text with note header template, the coder would see. If documented another way, it may result in coding pending for documentation and require more research to determine the provider did not see the patient.
- **Patient No Shows.**
  - The Encounter/FIN needs to be cancelled unless they can be rescheduled on the same day at a different time.

Why is the Ordering Provider showing as the responsible provider for tests ordered?

- **Studies like Radiology, the coder would not know who will read the report so it will display the attending provider registered to the account rather than a blank. For the other documents, the provider listed was manually entered to the responsible provider by the coder in 3M.**
  - In the practice space, it is helpful for the managers to use the slicer for patient location to filter to their practice/patient location rather than the provider slicer for individual providers.



Pending Reasons/Examples

Delinquent Category	Pending Reasons
Documentation	Documentation – Missing Discharge Summary • Missing entirely
Documentation	Documentation – Missing ED Note • Missing entirely
Documentation	Documentation – Missing Office Note • Missing entirely
Documentation	Documentation – Missing Operative Report • Missing entirely
Documentation	Documentation – Missing Co-Surgeon Note • Missing entirely
Documentation	Documentation – Missing Progress Note • Missing entirely
Documentation	Documentation – Missing Surgical Assist • Op Note may be there and missing the surgical assist. (why needed, who did it, what did they do)
Documentation	Documentation – Missing Discharge Summary • Missing entirely
Incomplete	Documentation – Missing Attestation • Shared visit (if seen by PA/NP and Physician, can collect at 100% if the attestation is added vs 85% if just done by PA/NP)
Incomplete	Documentation – Missing ED MD Procedure Note • ED note complete and indicates somewhere a procedure was done. Missing the procedure details.
Incomplete	Documentation – Missing H&P • Not seen often anymore.
Incomplete	Documentation – Missing Physical Exam • Missing from the note.
Incomplete	Documentation – Signature Missing (Preliminary Status) • Note done and not signed, still in preliminary status.
Incomplete	Documentation – Missing Procedure/Office Note Complete • Office note complete and indicates somewhere a procedure was done. Missing the procedure details.
Query	Query – Physician