The Importance of Finalizing Notes in a Timely Fashion

Last Modified on 12/01/2023 8:39 am EST

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Providers often ask why it's important to finalize notes in the EHR or what the industry standard is. There are four main reasons to finalize a note:

- To facilitate appropriate billing and payment.
- To prevent documentation errors.
- To protect yourself legally.
- To follow Best Practices for good patient care.

Let's start with timely billing and payment. No practice runs well without an effective strategy for turning work into claims and processing them in a timely fashion. Much of the work in Office Practicum is automatically added to a superbill when the work is done. For example, vaccines get administered, a rapid strep is processed, or a developmental screening tool is scored and discussed with the family. That information automatically gets dropped to the superbill and reduces missed opportunities for billing. However, the work of the E/M service does not get populated to the superbill until the note is finalized. If your billing staff has to constantly go back and forth and figure out which work is associated with an E/M service and ask for a code, it makes them very inefficient. For example, if there is a charge for a vaccine and vaccine administration code, was that a nurse-only visit or did the provider not finish their note yet? It may go out the door as a vaccine-only visit and the biller overlooks the visit and there is a missed opportunity for payment for all the hard work you did during the visit.

Some practices have manual processes where they process paper superbills. This is very inefficient and potentially leads to more revenue loss as they are trying to assimilate paper and electronic information. In addition, what if the provider says this was a 99214 visit, but then they don't ever go back and make sure the documentation reflects that 99214? At the time of the audit, the documentation does not support the code that was billed. And in payer audits, they can not only recoup monies for that visit, they can use that to reflect your "general overbilling practices" and demand payment back for a percentage of all 99214s that you "likely overbilled" for a period of one year or more.

Failure to finalize notes can cause confusion in subsequent documentation. I have seen many cases where staff or a provider opens a prior existing note and starts documenting contemporaneously on top of a visit that occurred during a prior encounter. I have also seen providers who said, "Who changed my note? I didn't write that." Another potential problem scenario might be that you see a patient for a sensitive issue, such as potential child abuse. If you never finalize your notes, your front desk staff can't conclusively determine if your note is truly finished. A few days later, DCS produces a release for those records; your front desk staff, after glancing at them, duly provides them. A vagary of language in your note -- an internal note you made to yourself which you intended to clarify later -- causes the family and state to misinterpret your documentation. If you finalize your notes, and your front desk staff is trained only to release finalized notes, then you can be confident that your notes, particularly when used for significant purposes like legal proceedings, will be accurate.

Perhaps the most important reason to finalize notes in a timely fashion is that it is a standard of medical care to do so. Just like they expect you to document date/time in your hospital records, or for signatures, the professional standard is to finalize a note within a "reasonable time period." Some experts say within two business days. Most agree certainly within a week. There is no

way providers can continue to hold specific information in their minds for more than a few days, which risks conflating that information with subsequent patient visits that occur during the normal course of business. It is standard practice during medical malpractice discovery that lawyers not only request your notes, but the EHR audit trail. They will have granular information about which person entered which information, at what time and often on which computer. There is no way to justify to a jury how in the world you remembered details of a visit that occurred more than a week or two prior to documenting the information. By not finalizing notes you leave yourself at significant risk.

There have been egregious cases where providers do not finalize notes at all and have been sanctioned by their state medical licensure board. Check with your state board and your malpractice attorneys, but if you are not following established practices in the professional industry, which is timely finalization of documentation, you are putting yourself, your patients and your practice at significant avoidable risk.

Lastly, and most importantly, it's good patient care. Our patients depend on us to deliver good care and communicate that information effectively. If you have a significant number of unfinalized notes, how can you tell if there are ones which are "relatively complete" or you got called to an emergency and "meant" to go back and write a note, but forgot? In addition, finalization of the note places the patient information on the OP Patient Portal. If you never finalize your notes, your patients and families lose the ability to review and reflect on what information you were intending to provide at the time of the visit. Don't your partners and your patients deserve to have timely reliable information?

So how do you make this happen? Create a culture of finalizing notes. I believe two days is reasonable. Beyond that, your memory is more unreliable. Get in the habit of checking every evening before you leave if there are any unfinalized notes. In our office, unless we are running out the door, we complete them the same day. If not, we arrive a few minutes early in the morning to clean up yesterday's work before we add a new pile that is surely going to accumulate during the new work day. Your administrator for the system gets an archiving alert periodically when they log in. Give them instructions to "auto-finalize" any notes that are more than seven days old. Start now to instill good habits of timely documentation and finalization of your notes. Your colleagues and patients will thank you.