Chapter 6 Medical Records

MEDICAL CHARTS

POLICY: Each patient seen within the Clinic must have an organized medical record that is legible, accurate, readily accessible, and easily retrievable.

POLICY:

1. A complete and accurate medical record will be maintained for each patient.

2. All records are kept in a secured place to assure limited access.

3. Standard forms and a predictable sequence of those forms will be maintained in the approved format unless specifically exempted by the Medical Director.

4. Patients may request their medical records be transferred to another physician or third party. This request will be honored only when accompanied by a signed release of information form.

5. The Clinic reserves the right to charge for the duplication costs involved in transferring medical records.

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GUIDELINES FOR MEDICAL RECORDS

Clinton Regional Hospital Clinic utilize an Electronic Medical Record (EMR) system. The EMR system follows the Guidelines for Medical Record Records.

CHART ENTRIES

PROCEDURES: Entries in the patient's medical record are made to reflect each client's event of care. Entries shall be characterized by general documentation guidelines, including the following:

1. Each patient shall have a unique medical record number or identifier assigned to his/her electronic record.

2. Each sheet/page entered into the patient chart should include patient's name and date of birth on the front side. (Any deviation from this policy must be approved by the Clinic Practice Manager.)

3. The original documents should be retained in the patient record

4. Factuality and objectivity:

a. Preliminary findings and observations noted as such.

b. Results of studies, test and evaluations and actions taken noted.

c. Freedom from negative comments about individuals, including the patient and family.

5. Accuracy: legible handwriting and no misfiled items.

6. Creation in normal course of patient care:

a. Entries made according to standard content.

b. Entries made on approved forms.

c. Abbreviations not to include any from the "DO NOT USE LIST."

7. Timeliness:

a. Notes will be done as close to the time of the actual event as feasible

b. Late entries and addendums so noted.

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CHART ENTRIES CONTINUED

c. Identifiable and clearly noted date (month/day/year in the following format: xx/xx/xxxx, i.e. 07/04/2011, with all digits spelled out).

8. The medical records are maintained in the clinic and are kept locked when the clinic is closed. The clinic staff is responsible for maintaining the records and ensuring that they are complete and accurate, readily accessible, and systematically organized.

OWNERSHIP OF MEDICAL RECORDS

The medical record shall be considered property of the clinic, which shall seek to safeguard it from unauthorized use, access, loss, or destruction. The patient's legally recognized interest in the content of the medical record shall be noted and honored by the development of appropriate access and release of information practices. Material shall not be accessed or released without patient consent.

The medical record shall not be removed from the premises except as required by specific subpoena or court order and approved by the Chief Officer or designee. Further, the documents shall not be placed in areas, workspaces, personnel lockers, or briefcases, where they are inaccessible for use by all authorized users.

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CHART INFORMATION ORGANIZATION

GENERAL ORGANIZATION OF MEDICAL CHART

To ensure consistency and accessibility of data, charts are recommended to be organized in the following manner.

INSIDE CHART CONTENTS The chart should include:

1. General release of information and permission to bill

a. HIPPA.

b. Consent.

c. Copies of required forms.

2. Most current patient demographic registration information.

3. Patient correspondence in date order (reverse chronological).

a. Letters.

b. Demographics.

c. Diagnostics.

d. Doctor correspondence.

e. Health history.

4. Patient Progress Notes, Diagnostic Tests, and Treatments

a. Progress notes.

b. Labs.

c. Hospital reports.

d. Emergency room reports.

e. Surgical reports.

f. Medication log.

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EXCLUDED CONTENTS

The following items should not be stored in the medical record:

- Encounter forms or superbills.
- Explanation of Benefits.
- Multiple copies of the same test results.

EXCEPTIONS

Clinic may request special exception to this organizational procedure through the Medical Practice Manager and/or Clinton Regional Hospital Administration.

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MEDICAL RECORD DOCUMENTATION

PURPOSE: Standardization of medical record documentation.

POLICY: The following standards for documentation will be adhered to by the Clinic.

PRINCIPLES OF DOCUMENTATION

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review of lab, x-ray data, and other ancillary services, where appropriate; assessment; and plan for care (including discharge plan, if appropriate).

3. Past and present diagnoses should be accessible to the treating and/or consulting Provider.

4. The reasons for and results of x-rays, lab tests, and other ancillary services should be documented and included in the medical records.

5. Relevant health risk factors should be identified.

6. The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient non-compliance should be documented.

7. The written plan for care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals and consultations; patient/family education; and specific instructions for follow-up.

8. The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.

9. All entries to the medical record should be dated and authenticated.

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Documentation is the recording of pertinent facts and observations about an individual's health history, including past and present illnesses, tests, treatments and outcomes. The medical record chronologically documents the care of the patient in order to:

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MEDICAL RECORD DOCUMENTATION CONTINUED

• Enable the Provider and other health care professionals to plan and evaluate the patient's treatment.

• Enhance communications and promote continuity of care among Providers and other health care professionals involved in the patient's care.

Facilitate claims review and payment

• Assist in utilization review and quality of care evaluations.

• Reduce hassles related to medical review.

• Provide clinical data for research and education.

• Serves as a legal document to verify the care provided (e.g., in defense of an alleged professional liability

claim).

WHAT ARE COVERED SERVICES?

Covered services are those services that are payable in accordance with the terms of the benefit plan contract by the insurer. Such services must be documented and medically necessary in order for payment to be made.

WHAT ARE MEDICALLY NECESSARY SERVICES?

Typically, payers define medically necessary services as those services or supplies that are:

1. In accordance with standards of quality medical care.

2. Consistent with the diagnosis.

3. The most appropriate level of care provided in the most appropriate setting.

The definition of medical necessity may differ among insurers. Medically necessary services may/may not be covered services depending on the benefit plan.

Documentation within the patient's medical record must answer the following questions.

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1. Is the reason for the patient encounter documented in the medical record?

2. Are all services that were provided documented?

3. Does the medical record clearly explain why support services, procedures, and supplies were provided?

4. Is the assessment of the patient's condition apparent in the medical record?

5. Does the medical record contain information on the patient's progress and on the results of treatment?

6. Does the medical record include the patient's plan for care?

7. Does the information in the medical record describing the patient's condition provide reasonable medical rationale for the services and the choice of setting that are to be billed?

8. Does the information in the medical record support the care given in the instance that another health care professional must assume care or perform medical review?

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CHART REVIEW PROTOCOL

POLICY: It is the policy of Clinton Regional Hospital Clinic to conduct comprehensive chart reviews on a routine basis. The following guidelines and review forms should be used to conduct the reviews (Form subject to change).

PROCEDURES:

Consistent and complete documentation in the medical record is an essential component of quality patient care. Reviewers look carefully at a sample of records during an external records review, using the Medical Record Review Summary Sheet. The summary sheet and the guidelines are provided for use in self-evaluation prior to an external survey. The guidelines are:

1. Each and every page in the record contains the patient's name and Date of Birth.

2. Personal/biographical data includes address, employer, home and work telephone numbers, and marital status.

3. Current consent included in chart.

4. All entries in the chart are dated and initialed.

5. The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one Provider reviewer.

6. Significant illnesses and medical conditions are indicated on the problem list.

7. If the patient has no known medical illness or conditions, the chart includes a flow sheet for health maintenance.

8. Medication allergies and adverse reactions are prominently noted in the record.

9. Past medical history (for patients seen three or more times) are easily identified and include serious accidents, operations, illnesses. For children and adolescents (18 years and younger), past medical history related to prenatal care, birth, operations, and childhood illnesses should be included.

10. For patients 18 years and over, notation concerning use of cigarettes, alcohol, and substance abuse is included.

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Chart Review Protocol Continued

11. Chief Complaint is noted.

12. Need for follow-up appointments are noted clearly in the chart.

13. No Show appointments are noted in the chart and attempts to contact patient to reschedule are

documented.

14. Immunizations are noted for pediatric patients (age 10 and younger).

Requests for immunizations should also be noted in the patient chart.

15. Documentation showing where preventive screening and services are offered, as appropriate for age and gender.

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CHART REVIEW

POLICY: It is the policy of Clinton Regional Hospital that all patients' charts should be reviewed prior to patient presentation, whenever possible.

PROCEDURE:

The nurse or receptionist reviews each chart for all necessary information including:

- Checking to see that all reports have been received from tests ordered and/or all consultant physicians.
- A record of the previous visit has been dictated, or progress notes entered, and filed.
- Transcription is complete and legible, and that all blanks have been filled in by the Provider who dictated the patient notes.
- Progress notes are legible and readable.
- Any forms that may be necessary for the impending visit are placed in the record.

If any of these items are missing, the person reviewing the chart should take steps to account for the missing information before the chart is returned to the file area.

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ACTIVE VS INACTIVE PATIENT STATUS

POLICY: Patients seen within the past three years and who have not been transferred to another Provider are considered active. Patients who have not been seen within three years, who have transferred to another provider, or who are deceased are considered inactive.

Chart Storage

1. Active Patients: The electronic medical record (EMR] of active patients will be stored at the Clinic site for immediate access.

2. Inactive Patients: All inactive patient records are stored on site.

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ACTIVE MEDICAL RECORD STORAGE AND RETRIEVAL

PURPOSE: To ensure consistency and accessibility of active patient medical records.
PROCEDURES: Specific procedures will be followed at each Clinic site.

All patient charts will be kept in an electronic format. Any forms presented to clinic on paper will be scanned into the patients chart and the paper copy will be destroyed or given back to the patient. No paper records are kept at the clinics

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TERMS OF RETENTION FOR CLINIC DOCUMENTS

PURPOSE: Storage and terms of retention of Clinic documents.

POLICY: Records of Clinton Regional Hospital Clinic shall be maintained in a safe and secure environment to assure compliance with certain state and federal regulations. Categories of records to be retained are listed below, with terms that the records are required to be kept.

PROCEDURE FOR STORAGE OF CLINIC RECORDS

1. All Clinic records are maintained through the current computer (EHR) System.

SCHEDULE FOR RETENTION OF CLINIC RECORDS

The Market Practice Manager/Clinton Regional Hospital will follow the following retention schedule:

CORPORATE RECORDS:	TERM OF RETENTION:
Articles of Incorporation	As long as corp, is active
Corporate	As long as corp, is active *(Sec. of State maintains a copy)*Indefinitely
Board minutes	Indefinitely
Miscellaneous correspondence & admin papers	1 yr
Provider employment agreements	6yrs
Deeds, Mortgages, Bill of Sale	Indefinitely
MANAGEMENT RECORDS:	**TERM OF RETENTION:**
Encounter forms (originals)	6yrs

All billing information is maintained with

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current computer billing system	N/A
All financial records including MOR's	3yrs
Deposit slips	6yrs

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Cancelled checks: all checks are generated thru Clinton Regional Hospital Accounting Department and will be retained as scheduled thru appropriate terms of that department

TAX RECORDS:

• All tax records are maintained thru Clinton Regional Hospital and will be retained as scheduled thru appropriate terms of that department.

MEDICAL RECORDS:

• Will be maintained according to state's statute of limitations for retention and destruction

• It is prudent to retain all patient records for a minimum of seven (7) years after the last treatment, or after the patient reaches their majority whichever comes last.

MISCELLANEOUS:	TERM OF RETENTION:
• Correspondence and administrative papers	6yrs

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DISPOSAL OF EXPIRED MEDICAL RECORDS

All medical records that have exceeded retention guidelines are securely stored until destroyed by professional shredding company. Company who provides secure shredding service to this clinic is:

AUTHORIZATION TO RELEASE

The Clinic Coordinator will approve all medical record information releases and ensure that all employees are aware of relevant guidelines. All medical record information release requests will go to Health Information Systems at Clinton Regional Hospital Clinic. The following guidelines are applicable for all medical record requests that are sent to Clinton Regional Hospital Health Information Management.

PROPERTY OF MEDICAL RECORD

1. The medical record is the property of the Clinic. It is maintained for the benefit of the patient The medical group has a responsibility to protect the record against loss, defacement and tampering, as well as any unauthorized use.

2. Written consent of the patient or legal qualified representative is required for the use and disclosure of a patient's health information for purpose of treatment, payment, and health care operations (i.e., quality, assessment, auditing, business planning, and general administrative functions).

3. Written authorization is required for uses and disclosures of health information for any other purposes to any person not otherwise authorized to receive this patient information.

4. The consent will be obtained on a "Consent for Release of Medical Information" form.

GENERAL REGULATORY REQUIREMENTS AND RELEASE OF INFORMATION

1. Health care providers, who are not members of the Clinic's medical staff, must present written authorization before information from the record may be released and/or transferred to them. There is no charge for this service.

2. Medical information is not to be released to life and/or disability insurance companies without a written authorization. Insurance companies will frequently utilize written consents signed at the time of application to obtain information. These are valid for a

period of up to 2 years from date of signature. An exception to these releases is psychiatric, alcohol or drug abuse information.

3. Information relating to treatment of alcohol or drug abuse may be released only with the written authorization of the patient that specifies release of this particular information or with a court order

4. Chart information regarding treatment of minors without parental consent needs to be marked "Confidential-Do Not Copy." The office staff is not to copy this information, if the record release is from a parent of the minor. If the record is being released by request of the minor, the information should be included.

5. Information of a psychiatric nature should be released only after consulting the psychiatrist, psychologist, or attending physician. Specific written authorization is required from the patient, and it must have an expiration date.

MEDICAL INFORMATION RELEASE WITHOUT CONSENT

1. Health information may be disclosed without authorization to public health authorities for public health purposes per local and state laws.

2. Health information may be used or disclosed for research without authorization if approved by an Institutional Review Board (IRB) or a privacy board.

3. State licensing boards may have access to the medical record as required by law or regulation.

4. Verbal requests for medical information must be limited to situations in which physicians of health care facilities treating the patient request information to provide good continuity of care in urgent situations.

5. When in doubt about a caller's identity, take name and phone number, then call back to verify. If still in doubt, request that they come by in-person.

PATIENT ACCESS TO MEDICAL INFORMATION

1. With written request, and with reasonable notice, Clinton Regional Hospital Information

Management (HIM) will provide a patient or designee, with a copy of the medical record. If the patient chooses, copies of the "pertinent" portion of the record may be obtained. HIM

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will respond in 48 business hours unless the record is off the premises. If it is off the premises, then HIM will respond in 7 days. If extenuating circumstances arise, HIM will provide notice that it needs an extension for an additional 30 days.

2. HIM will release the entire medical record as authorized by the patient, which includes notes and information contained from an outside provider.

3. Requests for medical records must contain the name and address of the patient and provider, the person or organization to which information is to be released, and a statement that the request may be revoked by the patient, the specific information requested, the date of the request, the purpose and signature of the patient. A statement that the request complies with these regulations, and has been approved by the attorney should be included.

1. HIM reserves the right to a five working day completion time for these releases.

2. If a patient requests a copy of health information, HIM may charge a reasonable, cost-based fee for the copying, per state guidelines.

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RECORDS OF ADOPTED CHILDREN

1. Prior to the release of any medical record, it will be thoroughly read to make sure that if it is an adoptee's chart, it does not contain pre-adoptive identifying data. If this type of information is found, it will be brought to the attention of the Health Information Management (HIM) director, who will handle this record release.

2. No one may release chart information with identifying data on an adoptee contained in it. All of these releases are to be completed by HIM. If it is a true emergency, copy only necessary information and blacken any pre-adoption identifying information, and proceed as usual with the release.

3. UPON NOTICE OF AN ADOPTION, THE MEDICAL PRACTICE MANAGER, IN CONJUNCTION WITH QUALITY/RISK MANAGEMENT & ATHENA/PPSI, WILL:

a. Copy information referring to the medical /mental condition of the child (including abuse or mistreatment).

b. Blacken names of original parent(s) or other identifying information (other names, addresses, phone numbers, etc.) on the copies.

c. Create a new medical record folder with the child's new name, new family information and altered records.

d. Delete child from former family listing/computer. (If outstanding bill, consult Billing Department)

e. Create new computer record for child's new identity with the new responsible party.

f. Type a note including the following, and send to the Legal File in the corporate offices:

- Date of Birth.
- Date of adoption.
- Original name of child, birth parents, chart number.
- New name of child, new parents, chart number.
- Date and sign.

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4. There is no other cross-reference of this information, except in the Legal file located in Administration.

5. File both medical records on the shelf.

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RELEASE OF INFORMATION TO A DIVORCED PARENT OF A DEPENDENT

Occasionally, questions arise regarding release of information to either one of a child's divorced parents. Either one of a child's divorced parents may request and receive medical information, with one exception: if a court has issued an order that limits the non-custodial parent's access, and if the provider has received a copy of the order or has actual knowledge of it, then information may not be released to that parent.

It is not necessary to inquire regarding the existence of a court order, as it may be assumed that if custodial parent has acquired a court order, that parent would have forwarded a copy to or, at a minimum, verbally reported its existence to the Provider. It is important, however that the medical record be reviewed prior to release of records to confirm the presence/acknowledgement of a court order.

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MEDICAL RECORD TRANSFER

RECORD TRANSFER - GENERAL GUIDELINES

1. Patients may request that their medical records be transferred to another physician or a third party. That request will be honored only after a signed Release of Information form is completed at the Clinic or Clinton Regional Hospital Health Information Management (HIM)

1.Information that may be released includes:

- Work status.
- X-rays and lab reports.

2.Consultant reports or physician notes are not to be released unless explicitly authorized by the physician.

TYPICAL REQUESTS

1. Request for transfer of medical records to another physician within the Clinic.
2. Request for transfer of medical records to another physician outside the Clinic.
3. Referral physician who is consulting on patient care.
4. Insurance companies requesting medical records.
5. Insurance companies requesting insurance form completion.
6. Workers Compensation.

TRANSFER OF ROUTINE PATIENT NOTES AND/OR TEST RESULTS

In cases where the Provider has referred a patient to another physician, routine requests for work status, x-rays and lab reports may be honored, so long as a signed Release of Information form is obtained from the patient in the Clinic. These transmissions should include only the minimum amount of information necessary to accomplish the goal.

All instances where any portion of a patient record is so shared must be documented within the record, telling the date, how the information was transmitted, why, and to whom.

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SUBPOENA COMPLIANCE

PURPOSE: Guidelines for subpoena compliance.

POLICY: It is the policy of Clinton Regional Hospital Clinic to cooperate with civil authorities and to comply with state and federal law regarding subpoenas.

PROCEDURES: All subpoenas served for clinical records will be processed by an externally contracted copy service employed by Clinton Regional Hospital. The transfer of clinical records is not to be done by the clinic employees.

All subpoenas for any type of records or for personal testimony of individuals are to be forwarded to the Medical Practice Manager, who will determine the parties responsible for follow up and who will notify the Risk Manager of the subpoena. The Risk Manager will do all other notification of personnel as deemed necessary.

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COURT ORDERS

PURPOSE: Court orders (issued by Judges) for patient information carry more force than subpoenas.

POLICY: All staff and providers should comply with court orders.

PROCEDURES: If a court order is received by any clinic staff member, the following procedures should be followed:

1. Bring any court order to the immediate attention of the Supervising Physician and/or the most senior staff person.

2. Contact the Medical Practice Manager immediately with regard to the details of the court order. The Medical Practice Manager will then contact the Quality/Risk Management Department.

3. The Quality/Risk Management Department will provide further instruction.

4. Consult legal counsel regarding compliance or any objection to compliance.