CLINICAL DOCUMENTATION & MEDICAL RECORD COMPLIANCE

As healthcare providers, we all have an ethical duty to preserve the confidentiality of information obtained from our patients during the course of care and treatment.

Throughout the centuries, confidentiality issues have been addressed; The Hippocratic Oath, Florence Nightingale Pledge, 1803 adoption of the AMA's Principle of Medical Ethics, American Hospital Association for Patient Rights, state and federal laws, and the latest HIPAA. Though ethical principles are not law, the courts have regularly ruled such to be legal duties, requiring healthcare providers to preserve the confidentiality of patient information. Violation of this duty may result in a negligent act.

The purpose of medical records is to:

1. Serve as a basis for planning patient care and or continuity in the evaluation of the patient's condition and treatment.
2. To furnish documentation of the course of the patient's medical evaluation, treatment and change in their condition
3. To document communication between all healthcare providers that provide or contribute to that patient's care. For this reason it is important to obtain **all** medical records from treating doctors or facilities that have treated the patient for the same presenting symptoms for which they came into your office.
4. Assist in protecting the legal interest of the patient

In short, medical records are designed to provide a medical history, determine if past treatment has been effective, to determine what other healthcare providers have done and protect the healthcare provider from negligence issues if the duty to protect the patient's rights has been violated. Not have all the medical record's is a major issue in negligent cases.

Medical records are should be kept on original paper retained for a period of a mandatory 5 years, with Statute of Limitations at 7 years. If microfilmed or kept on your computer, you should have a written policy concerning medical records, a custodian of those records and the originals on paper.

Who Has Access to Medical Records?
All patients have the right to access their own records and obtain copies of those records. In addition the patient's legal representative has the right to those records as long as the patient has signed a release of records to accompany any request from the legal representative. Other healthcare providers have the right to the records of the patient if they are directly involved in the care and treatment of the patient. Care can be a referral to their office or joint care between you and another healthcare provider. Also a competent adult appointed in writing by another competent adult @ (living will or healthcare surrogate). A parent of a minor, and a personal representative of an estate also have access to a patient's medical records.

All patients have the right to access their own medical records and obtain copies of those records simply by signing a release of records form. By doing this, you are protecting yourself from releasing medical records without a consent by the patient. There are other means by which medical records can be released. They are as follows:

There are exceptions to medical records releases:
1. Insurance carriers of the patient you are treating
2. Subpoena
3. Super-Confidential records: Court order, but must meet a strict need, but there are exception to this release also.
4. Emergency medical treatment: Must **attempt** to get consent if you can

What are the Requirements?
All states have similar and minimal record compliance requirements. As part of the "confidentiality of medical records", it is important to know what is required by law to be a part of your medical records or patient charts. There are both state and federal laws concerning your patient charts and what is required to be in them. The following list will give you a guideline as to medical chart requirements.

1. History, patient intake form with basic information, @ chief complaints, and history of complaints as told by the patient, subjective complaints or presenting complaints. Make sure you have a place for the patient to sign the history or intake form. This form acts as a **general consent** to treat the patient
2. Past and social history of the patient

3. Diagnosis, impressions and prognosis of the patient
4. Review of symptoms
5. Physical examination, re-examinations (objective findings)
6. Any laboratory findings
7. X-ray reports (make sure you read and initialize reports) (signing patient charts attests that they are accuracy and you have reviewed them)
8. Diagnostic tests, impressions, interpretations
9. Prognosis notes (signature of the doctor and date at the bottom of each completed page attesting to the accuracy of the records). Progress notes also justify care and establish medical necessity and should be written on a daily basis. In addition number the pages.
10. If the progress notes are written by someone else, the notes must be signed by the doctor within 7 days after the initial entry into the charts.
11. Document discharge of MMI of the patient: reason, diagnosis, treatment, findings, condition of the patient at the time of discharge
12. Any other medical records of the patient from past care by other healthcare providers.
13. Any consultations to render an opinion, written or verbally and any review of your medical charts/records.
14. Medical consents to treat explained to the patient by the doctor and signed by the patient. **

** Medical consent issues in negligent cases can be tried and ruled upon separately. (Recent ruling by the Wisconsin Supreme Court)

15. Notes of any healthcare provider that assumes care at any time.

Medical records should contain enough information to identify the patient, support a diagnosis, and justify treatment / care, document course of treatment and the results of that treatment; including history, examination, test results, reports, signed and initialized records. Maintain records in a legible and accurate manner, which clearly demonstrates the course of treatment undertaken.

In addition here are some tips about your chart records:

1. Keep a legal section in your patient chart
2. Don't alter any record
3. Use a line through an error and initialize that correction. Don't use whiteout
4. Make sure the patient's name is on all chart pages

5. Document compliance @ no shows, cancellations and reschedules.
6. Document all orders and referrals
7. Document any specific instruction you give the patient.

Keep in mind that lack of documentation or failure to document your charts with essential information falls below the standard of care. Failure to document is one of the most common errors and fraud issues doctor's face. In addition falling below the standard of care may become a negligent issue if a patient is injured or perceives an injury and sues you.

Your patient chart should provide a reason for treatment. Missing or lack of documentation equals **"no treatment".**

Correctly documenting your patient charts / medical records is the best way to ensure that investigator doesn't come knocking at your door. Remember that improper records and lack of documentation can constitute fraud. Be aware of the criteria for medical necessity, the need for treatment and document your patient records properly and within the minimum standards set forth by statutes or your board.

Documentation Tips:

1. Keep a legal section in your patient chart
2. Don't alter any medical record
3. Use a line through any mistakes or errors and initialize the correction.
4. Do not use whiteout
5. make sure the patient's name is on all chart papers
6. Document compliance and non-compliance
7. Document orders and referrals
8. Document any specific instruction you give to a patient.