Quick Start Guide: Documentation

PRINT

Documentation

WHAT ITEMS SHOULD BE PRESENT IN A PATIENT'S MEDICAL RECORD?

The importance of careful and accurate documentation in the medical record cannot be overstated. In a malpractice lawsuit, the medical record is an essential element of your defense, and its contents may impact the outcome. Clear and comprehensive documentation also enables the physician to plan and evaluate treatments and to communicate with other providers. Guarding the integrity of office practice medical records is the responsibility of the physician(s). Policies and procedures should govern how and when documentation occurs in your office.

The following is a list of recommended medical record components. If you have an **electronic medical record** (EMR), it may include pre-existing templates to capture all of this information. However, it is important to review the template for completeness before using it. Every office has different needs, and you may find that you need to customize the EMR template for your practice patterns. Additionally, some systems allow you to customize a template for your medical specialty. Check with your EMR vendor to determine whether customized templates are available. *Refer to Section 24 for more information about electronic medical records.*

All medical records should contain:

When relaying results and follow-up instructions to the patient, document who was spoken with, the date, and the name of the staff member who communicated the results.

Diagnostic images are part of the medical record, even though they are not always kept with the patient's record.

- Clear **identification** of the patient, including the patient's full name and medical record number, on every page in the record and on the folder or cover (if using paper records).
- A clear **medical history** for each patient. If the history is documented by someone other than the physician (such as the patient or a clinical assistant), the physician should countersign the information to indicate awareness and understanding. Any inconsistencies in the medical history or abnormal responses should be addressed in writing. The medical history should be updated at least annually, even if the notation is simply, "no change in medical history."
- A record of **allergies** reported by the patient (or discovered in the course of treatment). If the patient reports no allergies, this fact should be recorded as well. Allergies should be

documented in a consistent, prominent, and easily- found place in the record. All allergy notations should be updated at each visit and when new medications are prescribed.

- A **problem list** of the patient's chronic and acute conditions. Update this list at each visit.
- A running list of **medications** taken by the patient. The list should include medications prescribed at your office and at other offices. Over-the-counter drugs, including herbal medicines and other supplements, also should be included. The patient should be questioned at each visit about the medications he or she is currently taking so that the list can be revised.
- A **progress note** for each visit that is dated, reviewed, and signed or initialed by the physician.
    - If a physician uses a pre-printed template, all blanks on the form should be filled in or accounted for with some notation like "n/a" for "not applicable."
    - If a consistent format is used, documentation will be easier to perform and easier for others (such as subsequent treating physicians) to read and understand.
- Any **diagnostic testing** performed on the patient. each testing event should be documented with:
    - Test result (including interpretations of diagnostic images),
    - Date results were received,
    - Date results were reviewed by the physician,
    - Physician's signature, and
    - Follow-up instructions.
- A documented **treatment plan**, based upon the diagnosis or diagnoses.
    - Progress notes of subsequent office visits should demonstrate adherence to the plan and the results.
    - If the treatment plan includes elements that are not standard for the usual treatment of the condition (such as increased dosage of medications or the use of different devices), the plan should acknowledge this and explain the deviation.
    - If events or the patient's changing condition dictate a change in the treatment plan, the altered plan should be noted and a rationale given for the changes.
    - If the patient refuses to follow the treatment plan (for financial or any other reasons), this information also should be documented.
- Documented **patient education efforts**.
    - Patient education may be as simple as a pre-printed leaflet about a particular disease, or as complex as training the patient to monitor blood glucose levels at home. Be sure to archive any pre-printed copies of education material given to patients.
    - All education efforts should be recorded in the record by the physician or staff member who provided the instruction, with an indication of the patient's comprehension and voiced intent to follow instructions.
    - Documentation of education should also include a "return to office" notation: the date or approximate period within which the patient has been told to return, even if it is only to return as needed.
- **Correspondence** concerning the patient, to or from other physicians or other parties.
- Office copies of **hospital records**.

WHAT ITEMS SHOULD NOT BE PRESENT IN THE PATIENT'S MEDICAL RECORD?

Ideally, a patient's **financial records** should be kept separate from information about treatment. We recommend this separation to avoid the appearance that the physician made treatment

decisions based on the patient's ability to pay.

However, constraints of space and time do not always permit such an arrangement. The next best system, therefore, is a segregation of these documents in their own section at the back of the record or on the left side so that a physician need not look through them while in search of medical information. If you are using an EMR, you may have the ability to document payment information in a separate screen or section of the system.

Negative, subjective comments about the patient or his or her behavior should never be a part of the record. When describing an altercation or other unpleasant incident in the record, or when a patient has been non-compliant with recommended treatment or refuses to cooperate in treatment or follow recommendations, be completely factual, describing the facts of what occurred without comment. Similarly, avoid using exclamation points or other unusual notations.

Correspondence or documentation having to do with a **potential claim** against the physician or practice, including all correspondence and documentation between the physician and the physician's attorney or professional liability insurer, must not be placed in the record.

Incident reports must not be placed in the patient's medical record. They should be maintained in a separate file.

It is important to remember that anything placed in the patient's record becomes a part of the "official medical record." if there is a signed request from the patient to release his or her **entire** medical record, you must copy and release everything you have in the official record.

IF A PATIENT BRINGS IN VOLUMES OF RECORDS FROM ANOTHER PRACTICE, DO WE HAVE TO KEEP ALL THOSE RECORDS AS PART OF OUR RECORD?

We do not recommend discarding old records without reviewing their contents.

However, if a patient brings a large amount of records to your practice and you do not have room for storage, the physician should review the records to determine which parts are necessary to retain for ongoing treatment. You may then offer to return the unnecessary records to the patient, stressing the point that what has been returned is now an incomplete medical record. If the patient does not wish to take back the incomplete record, advise that you may destroy the remaining information.

Alternatively, you might ask the previous practitioner to provide a summary of the patient's records for your files.

SOME OF OUR PHYSICIANS TAKE MEDICAL RECORDS HOME FOR REVIEW IN THE EVENINGS. IS THIS AN ACCEPTABLE PRACTICE?

Curi strongly advises against removing medical records from the office for the following reasons:

Confidentiality
There are numerous scenarios in which medical records taken outside of the office could get into the wrong hands. What if a person's car is stolen, or an accident happens while records are in the car? Personal and confidential medical information could then be broadcast for the world to see, and the practice or physician could be held liable.

Defense of a Claim
When a record is removed from the secure environment of the medical office, the chance of losing that record increases. If a physician is sued for malpractice and does not have the record, that physician's defense may be adversely affected.

Continuity of Patient Care
If a medical record is missing or lost and that patient calls or comes into the office with a problem, the physician will not be able to refer to the record for medical history and other important patient information. This could lead to mistakes and/or an unexpected bad outcome for the patient.

Security of Electronic Records
If your physicians can log on from a remote location and review records, you must ensure the security of the information. The HIPAA security rule requires that reasonable steps be taken to secure patient records.

This includes such actions as requiring passwords, limiting access to specific records or portions of records based on pre-set criteria, and using state-of-the-art firewalls and other anti-hacking measures if the system is accessible from outside the practice. In order to keep your electronic information secure, work with your EMR vendor to ensure that your system is Up-to-date on the latest security measures. *Refer to Section 24 for more information on electronic medical record security.*

When reviewing electronic medical records remotely on a desktop or laptop computer, the physician reviewer should never leave the computer unattended for possible access by others. If it is necessary to leave the computer, even for a brief moment, access to the computer screen should be locked.

ARE WE PERMITTED TO ASK FOR A PATIENT'S SOCIAL SECURITY NUMBER?

Yes. There is no law that prevents a medical office from asking a patient for his or her Social Security number; however, a patient may decide not to provide it to you. According to the Social Security Administration:

If a business or other enterprise asks you for your number, you can refuse to give it. However, that may mean doing without the purchase or service for which your number was requested. For example, utility companies and other services ask for a Social Security number, but do not need it; they can do a credit check or identify the person in their records by alternative means. Giving your number is voluntary, even when you are asked for the number directly. If requested, you should ask why your number is needed, how your number will be used, what law requires you to give your number, and what the consequences are if you refuse. The answers to these questions can help you decide if you want to give your Social Security number. The decision is yours.

This means that patients may refuse to give their Social Security numbers, but also that your office may refuse to provide services if you use Social Security numbers for setting up accounts or for internal verification purposes.

For more information about Social Security numbers, visit the government's website at www.socialsecurity.gov

Although the law permits your office to collect and maintain patients' Social Security numbers, if you choose to maintain this information we **strongly** recommend that you have internal policies that address how you will keep this information secure and how you will respond to breaches of this information. These policies should comply with applicable laws about personally identifying information. Also, be aware that both State and Federal laws require your office to notify individuals, and, under certain circumstances, government agencies, if you discover that this information has been inappropriately used or released.

ARE THERE ANY GUIDELINES FOR "SIGNING OFF" ON DICTATION?

Ideally, the physician who dictates notes on office visits will be able to review and sign them shortly after transcription. This timetable is most conducive to catching errors made by the physician or others. Regardless of when the progress notes are signed, however, the physician will want to review the previous ones when the patient returns to the office.

The notations "Dictated but not read" or "Dictated but not read to expedite delivery" are **not** recommended. These notations call attention to the fact that the physician is not reviewing his or her transcription and, in litigation, could be used to make the physician look sloppy, careless, or too busy to pay attention to details.

The obvious risk of not reviewing transcription is that an error made by the dictating physician or the transcriptionist will not be caught. Then, the physician or a subsequent medical care provider will rely upon the false information, and the patient's care could be compromised.

Physicians also need to realize that, in litigation, the patient's attorney will seek to hold the physician to the transcription of his or her dictation, even if it is unsigned or unread. Additionally, if you are supervising another healthcare provider and "sign off" on his or her note(s) as a matter of formality without correcting any mistakes, the patient's attorney is likely to contend that actual supervision was absent.

If you use voice-recognition software to dictate, be sure to review the dictated information to ensure the clarity and legibility of the note.

Finally, both Medicare and Medicaid require that medical records supporting the medical necessity of an item or service be signed, dated, and time-stamped ("authenticated") before the bill for that item or service is submitted. Dictation that is not authenticated may jeopardize the practice's reimbursement for the service.

IS THERE A TIME FRAME WITHIN WHICH WE ARE REQUIRED TO COMPLETE DOCUMENTATION IN A PATIENT'S MEDICAL RECORD?

In order to keep the information fresh and accurate, the patient's record should be completed as soon as possible after each encounter. We recommend a turnaround time of one business day (24 hours). This policy can help ensure that medical records remain available and are complete for the patient's next visit or telephone call, and it improves the credibility of the dictation.

However, we recognize that a 24-hour turnaround time is not always practical. Your practice should set a standard that realistically can be met by all providers. A reasonable **maximum** turnaround time is three business days (72 hours). Note, however, that your policy is only as good as your practice's adherence to it. For the policy to be effective, compliance should be monitored.

The Joint commission requires physicians in **hospital** settings to complete their medical records no later than 30 days after discharge, and neither Medicare nor Medicaid should be billed until the record is complete.

You should be aware that if your practice is a partnership, **each physician might be held vicariously liable for the actions of the others**. Those physicians who are careful to complete dictation on time thus can suffer for the actions of those who are not as careful.

IS IT ACCEPTABLE TO USE SIGNATURE STAMPS IN OUR OFFICE?

We strongly advise against the use of signature stamps, primarily because Medicare no longer accepts stamp signatures as appropriate authentication for reimbursement purposes.

When a physician signs his or her name to a medical record, laboratory report, or pathology report, he or she is acknowledging responsibility for the information contained in that document. A signature is verification that the physician has read the information, agrees with it, and thereby assures that the information is accurate.

Medical records are a physician's primary defense tool in the event of a malpractice lawsuit. Any erosion of credibility in the record will be detrimental to the defense. Because a stamp can be used by anyone, the credibility of any document signed by a stamp is questionable.

This advice also applies to electronic signatures. No one other than the physician should be able to electronically sign his or her notes. Do not allow staff members to access other users' login information for your EMR.

HOW SHOULD WE DOCUMENT TELEPHONE CALLS?

Documentation of patient telephone calls provides evidence of care rendered and improves continuity of care. It can also help minimize the risk of delay in treatment.

There must be a record of:

- The patient's name,
- The name of the person who called,
- The time of the call, and
- A description of the problem or question.

If the issue cannot be resolved by the person taking the call, he or she must sign the message and deliver it to the proper person, indicating urgency if necessary.

The person responding to the patient call should document:

- The time of the return call,
- Any questions asked and answered,
- The specific advice given and the physician-approved protocol used, if applicable,
- Prescriptions called in or over-the-counter medications recommended,
- Instructions given to make an appointment, come in immediately, or go to the emergency Department, and
- The patient's response to and understanding of the instructions.

The person speaking to the patient should sign the documentation associated with the call. If the patient calls again later to report the results of advice taken, this call, too, should be documented.

If a patient's call is not taken or handled by the patient's usual physician, make an effort to inform the regular physician of the developments. This is especially important if the patient is high risk.

Any staff-generated telephone notes that include verbal orders should be co-signed by the ordering physician. Physicians also should document patient calls they receive after office hours. Make sure **all** telephone call documentation is maintained in the patient's record.

Documentation of after-hours calls may be accomplished by one or more of the following methods:

- Physicians may wish to keep a portable dictation device so after-hours calls can immediately be recorded.
- Offices can maintain a dictation system that allows physicians to call in and dictate from home. These systems can be used for documenting after-hours calls.
- Some EMR systems allow the physician to log on from home and enter notes in the record. Check with your EMR vendor to determine if this is an option with your system.
- Some physicians use voicemail to record messages about after-hours calls. Messages are then transcribed into the record and signed in the office by the physician.
- If the office uses an answering service, the service's record pages can be used as a reminder to create documentation of after-hours calls.
- If there is no dictation system available, physicians can handwrite their notes at home and bring the paper in to the office to be entered into the patient's medical record. However, this is the least optimal choice, as this process is more likely to compromise the security of the patient's medical information.

HOW SHOULD WE HANDLE PATIENT REQUESTS TO AMEND RECORDS?

The HIPAA privacy rule allows patients to inspect and request amendments to their medical records. A physician must make a good faith determination whether to accept or deny such requests.

If a patient asks for an amendment to a record:

1. Ask the patient to submit the request in writing.
2. Within 60 days after you receive the written request to amend a record, you either must accept the amendment, deny the amendment, or inform the individual that you need more time to respond to the request. You should include the reason for the delay and the date you will complete the response to the request. You may have an additional 30-day period within which to respond to the request.
3. Determine if you will accept the amendment. amendments may be denied for any of the following reasons:
    - The information is already accurate and complete,
    - Your providers did not create the information,
    - The information is not actually a part of the official medical record, or
    - The information would not be available to the patient under the HIPAA access standards.
4. If you deny the amendment:
    - Explain the reason for your denial in plain language,

- Give the patient information on how to submit a written statement disagreeing with the denial, and
- Tell the patient that you will include copies of the request for the amendment, documentation of the denial, and any future record releases (if requested).

5. If you accept the amendment:
   - Make the change in the patient's record,
   - Notify the individual of the change, and
   - Notify other parties who have previously received and relied on the information.

If a patient's request to amend a record is submitted long enough after treatment that the physician cannot verify whether the requested amendment is needed, it is appropriate to deny the request because – to the best of the physician's recollection – the record already is accurate and complete.

Reference

45 CFR 164.526