Standards for Medical Record Keeping

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Business and Professions Code § 2266:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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Source of Medical Record Standards

- Federal Law - Health Insurance Portability and Accountability Act (HIPAA)
- State Law - Knox-Keene Act (California)
- Federal Regulations - Medicare Conditions of Participation
- Combined Federal & State Regulations – Medicaid (MediCal)
- Accreditation Bodies - The Joint Commission

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The Joint Commission

- Medical record must contain specific clinical, demographic, and other pertinent information

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Medicare Conditions of Participation - 1

- Every hospital must
  - establish a medical records service
  - Use a system to ensure integrity of medical records
  - Assure medical records are accurate, properly retained, & accessible
- All medical records must contain information that
  - Justifies admission & continued hospitalization
  - Supports the patient's diagnosis
  - Describes the patient's progress
  - Describes response to medications and services

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Medicare Conditions of Participation - 2

- Hospital must ensure all medical record entries
  - Must be legible and complete
  - Must authenticated and date by responsible person
  - Must describe patient's progress and response to medications and services
- Author of each medical record entry
  - Must be identified
  - Must authenticate his or her entry
    - May be by signature, written initial, or computer entry
- Medical records must be retained for at least 5 years

Medicare Conditions of Participation - 3

- Hospitals must
  - Have a system of coding and indexing medical records
  - Ensure that unauthorized individuals cannot gain access
  - Release medical records only in accordance with federal and state law, court orders, or subpoenas.
- Each written medical record and EHR screen must
  - Contain patient identification (name + other identifying info like MRN or DOB)
  - Patient identification printed on both sides of paper-based records
  - Patient identification on each page of multi-page reports
  - Identify the medical facility (name, mailing address, telephone number)
- Aliases are permissible
  - Risk of adversely impacting continuity of care

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Administrative Data in Hospital Inpatient Medical Record

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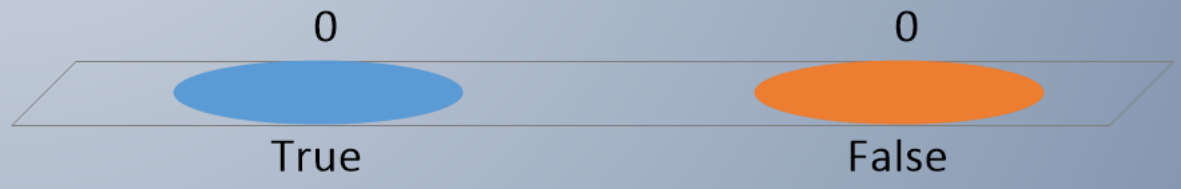
Question (True / False)

Upon admission, all patient records must contain documentation as to whether an individual has executed an advance directive.

1. **True**
2. **False**



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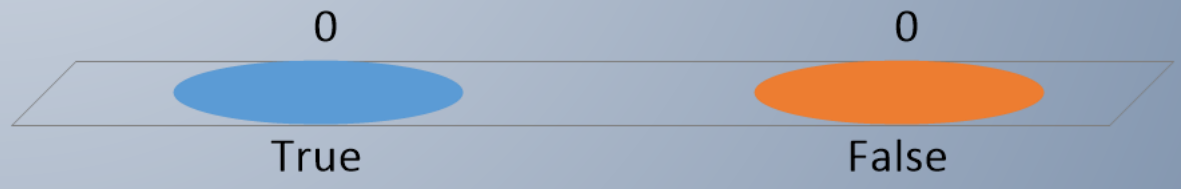
Question (True / False)

The identification and financial sections of the face sheet may be completed by the admitting nurse when the patient arrives on the nursing unit.

1. **True**
2. **False**



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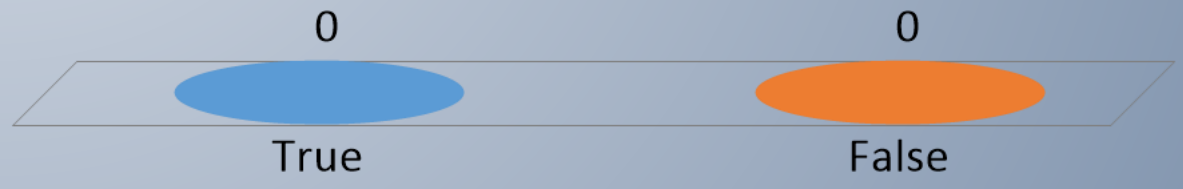
Question (True or False)

Providers may complete their documentation anytime after the patient has been discharged.

1. **True**
2. **False**



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Medical Records

- Contain important administrative information:
  - Demographic
  - Socioeconomic
  - Financial

- Administrative data includes
  1. Face sheet
  2. Advance directives
  3. Informed consent
  4. Patient property form
  5. Birth certificate (copy)
  6. Death certificate (copy)

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Face Sheet

- The Joint Commission
  - Does not specifically require face sheet
  - Requires all medical records contain identification data
  - Medical records must be completed w/i 30 days following discharge

- Medicare Conditions of Participation Facesheet must contain:
  - Patient identification and demographic information
  - Financial data
  - Clinical information including admitting diagnosis & final diagnosis
  - Final diagnosis & chart completion must be w/i 30 days of discharge
  - May be paper-based or computer-generated
  - Usually filed as the first page of patient record

Face Sheet & Uniform Hospital Discharge Data Set

- UHDDS defines a minimum core data set hospital must collect for each hospital discharge that are required by Medicare and Medicaid programs and usually found on Face Sheet

1. Personal Identification / Unique identifier
2. Date of birth
3. Gender
4. Race and Ethnicity
5. Residence
6. Health Care Facility Identification Number
7. Admission date and Type of Admission
8. Discharge Date
9. Attending Physician Identification
10. Surgeon Identification
11. Principal Diagnosis
12. Other Diagnoses
13. Principle Procedure and Dates
14. Disposition of Patient at Discharge
15. Expected Payer for Most of This Bill
16. Total Charges

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Face Sheet & National Committee on Vital and Health Statistics

- NCVHS has standard data set for both ambulatory and inpatient settings usually found on Face Sheet

1. Personal / Unique Identifier
2. Date of Birth
3. Gender
4. Race and Ethnicity
5. Residence
6. Living Arrangement
7. Marital Status
8. Self-Reported Health Status
9. Functional Status
10. Years Schooling
11. Relationship to Subscriber
12. Current or Most Recent Occupation
13. Type of Encounter
14. Admission Date (inpatient)

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Face Sheet - Where the Information Comes From

- Patient registration personnel
  - Enters patient identification and financial data
    - On or prior to admission
    - Financial data includes 3rd party payer information
- Admitting clerk
  - Enters Admitting Diagnosis (obtained from admitting physician)
- Attending physician
  - Documents
    - Principal & Secondary Diagnoses,
    - Co-morbidities
    - Complications
    - Principal & Secondary Procedures
- Coders
  - Assigns numerical and alphanumerical codes (ICD-9-CM, CPT, and HCPCS codes) to all diagnoses and procedures.

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Diagnoses, Comorbidities, & Procedures

A elderly man with hypertension fell and was admitted with a open fracture of the right tibia and vague complaints of abdominal pain. The patient was taken to the operating room for definitive repair of the tibia. Two days later he developed infection at the site of the surgery, his abdominal pain worsened, and his blood pressure was abnormally high. He was started on antibiotics and additional medication for his blood pressure. A abdominal CT scan revealed appendicitis. He underwent an appendectomy, improved and was discharged eight days later.

- What is the primary diagnosis?
- What is the secondary diagnosis?
- What is the comorbidity?
- What is the complication?
- What is the principal procedure?
- What is the secondary procedure?

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Advanced Directives

- Laws
  - Federal Patient Self Determination ACT (PSDA) of 1990
  - California Advance Health Care Directive (AHCD) [Probate Code §§4600-4806]
- Advanced Directives superseded by AHCD
  - Natural Death Act Declaration
  - Directive to Physicians
  - Durable Power of Attorney for Health Care

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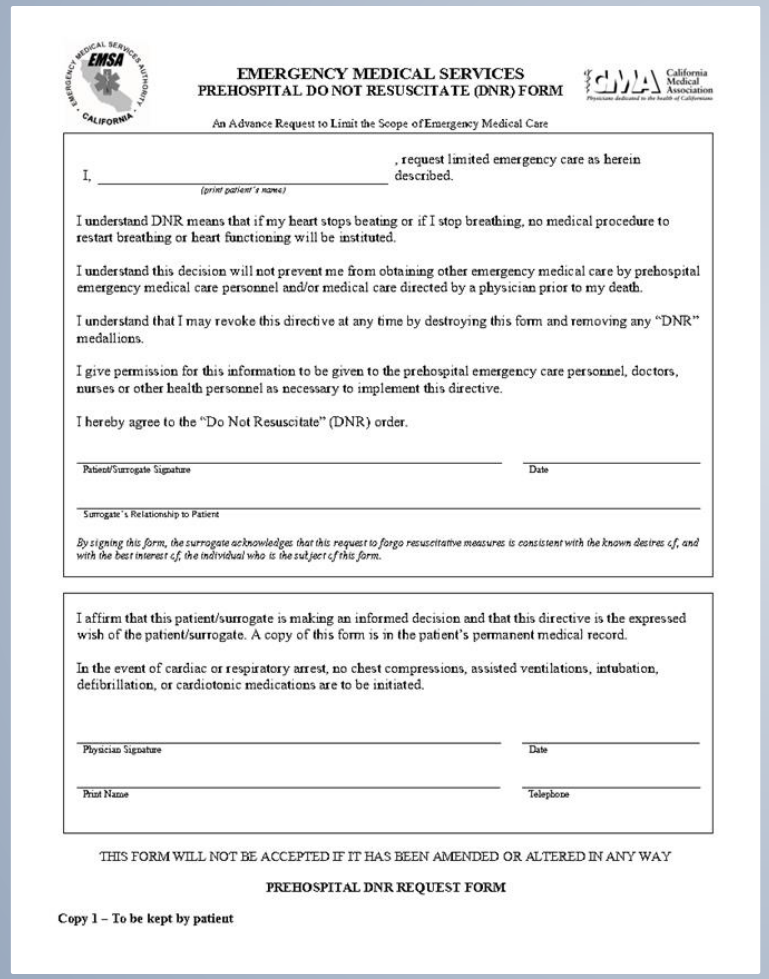
Do Not Resuscitate Order(DNR)



EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____ (print patient's name), request limited emergency care as herein described.

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate Signature _____ Date _____

Surrogate's Relationship to Patient _____

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

Physician Signature _____ Date _____

Print Name _____ Telephone _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 1 – To be kept by patient

- No federal DNR statute
- California DNR
  - Must be signed by patient and physician

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Informed Consent

- The Joint Commission
  - Patient must consent to treatment
  - Medical record must contain evidence of consent
  - Medical staff must develop policies for informed consent
- Medicare Conditions of Participation
  - Medical records must contain written patient consent for treatment

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Other Consents

- Consent to Admission
  - Health Insurance Portability Act (HIPAA) privacy rule no longer requires hospitals to obtain consent for admission
- Consent to Release Information
  - Consent to release information for reimbursement usually part of consent to admission
  - HIPAA privacy rule no longer requires consent to release information for reimbursement, research, or education purposes
  - Release of information for other purposes require separate consent

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Certificate of Birth

- National Center for Health Statistics (NCHS)
  - Developed standard certificate of birth
  - States can adopt certificate for their use
- Birth certificate contents include:
  - Infant's and parents' demographic information
  - Parents' occupation, education, ethnicity, race
  - Pregnancy information
  - Medical risk factors, complications, and/or abnormal conditions of newborn
- Certificate information is submitted to state departments of health within 10 days of birth

California Law Regarding Live Births

- California Health and Safety Code § 102400:
  - Live births must be registered with local registrar w/i 10 days
  - Physician in attendance at birth responsible for registering

California Health and Safety Code § 102405:

- If no physician, either parent or individual actually present at birth can enter information on certificate, secure signatures, and register the certificate

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Certificate of Death

- National Center for Health Statistics (NCHS)
  - Developed standard certificate of death which states can adopt
- Death certificate
  - Must be signed by a physician
  - Filed with state department of health usually w/i 5 days

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California Law Regarding Deaths

California Health and Safety Code §§ 102850:

- Physician must immediately notify coroner when death occurred under following circumstances:

  a) Without medical attendance.
  b) During the continued absence of the attending physician and surgeon.
  c) Where the attending physician and surgeon or the physician assistant is unable to state the cause of death.
  d) Where suicide is suspected.
  e) Following an injury or an accident.
  f) Under circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

- Any person who does not notify the coroner as required is guilty of a misdemeanor.

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Patient Property Form

- Record of items brought by patient to hospital
  - Signed by patient and hospital staff member

Clinical Data in Hospital Inpatient Medical Record

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Emergency Department Record

- The Joint Commission
  - Emergency Department medical records must contain:
    - Time and means of arrival
    - Whether patient left against medical advice (AMA)
    - Conclusion at termination of treatment
      - Final disposition
      - Condition at discharge
      - Instructions for follow up
  - Medical record must be authenticated by responsible practitioner
  - Copy of ER record must be sent to provider who administers follow-up care

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Ambulance Report

- Generated for patients transported by ambulance to ED
- Documents
  - Vital signs
  - Level of consciousness
  - Appearance
- Copy of report placed in medical record

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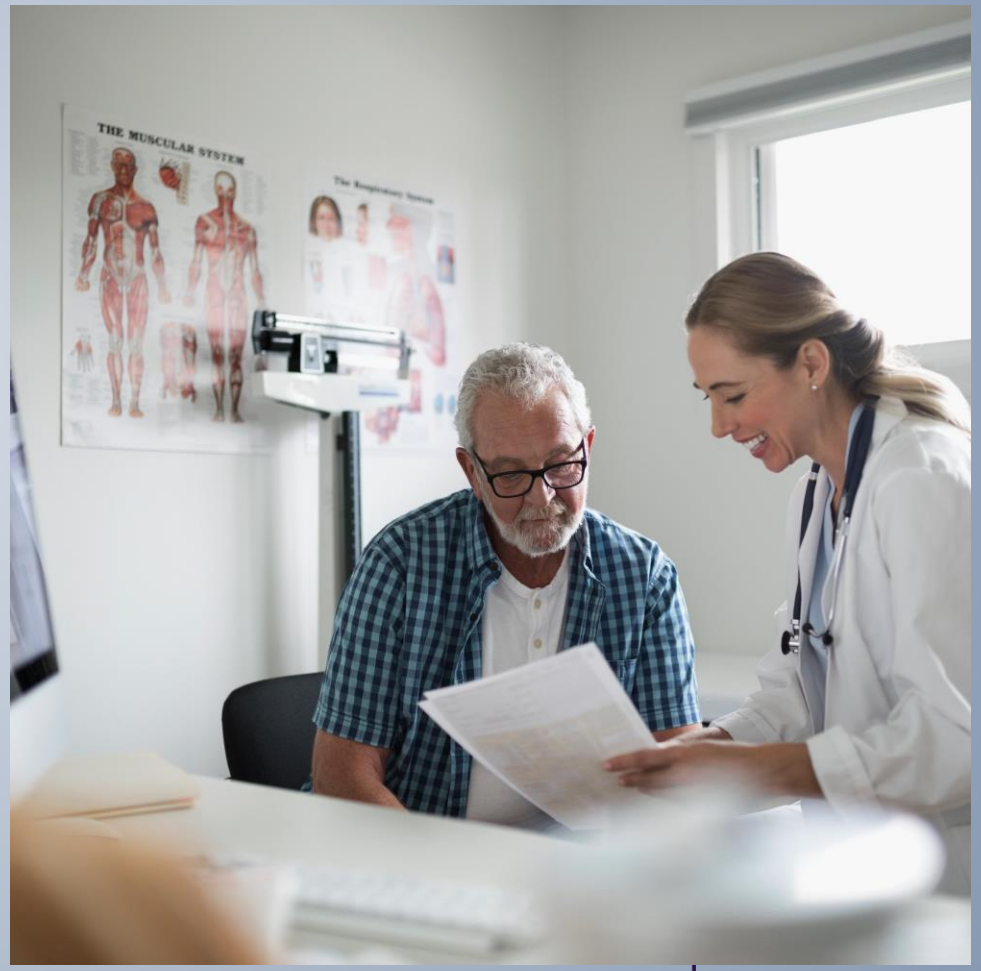
Emergency Medical Record Contents

- Patient identification
- Time and means of arrival at the ED
- Pertinent history of illness or injury
- Physical findings, including vital signs
- Emergency care provided prior to arrival
- Diagnostic and therapeutic orders
- Clinical observations, including results of treatment
- Reports of procedures, tests, and results
- Diagnostic impression
- Conclusion at termination of evaluation/treatment
- Evidence of a patient leaving against medical advice



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Discharge Summary (Clinical Resume)

- The Joint Commission
  - Discharge summary (or clinical resume) must be completed by attending physician
  - Must document "the use of approved discharge criteria to determine the patient's readiness for discharge"
- Medicare Conditions of Participation
  - Medical records must document a discharge summary
- Treatment of minor problem
  - Only needs a final progress note
- Transfer to a different level of case
  - Discharge summary is called a *transfer summary*
  - Can be documented in progress notes if same practitioner continues to provide care

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History and Physical Examination

- The Joint Commission & Medicare Conditions of Participation
  - H&P must be performed and documented in medical record within 24 hours after admission (including weekends & holidays)
  - May use a reviewed/updated H&P completed within 30 days prior to admission
  - If patient is scheduled for surgery, completed H&P must be in medical record before surgery

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Elements of History

- Chief Complaint
- History of Present Illness
- Past Medical/Surgical History
- Family History
- Social History
- Medications
- Review of Systems

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Elements of History

- Chief Complaint
- History of Present Illness
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- Review of Systems

- General
- Skin
- Head
- Eyes
- Ears
- Nose
- Mouth
- Throat
- Breasts
- Respiratory

- Cardiovascular
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Neurological
- Endocrine
- Psychological
- Hematologic / Lymphatic
- Allergic / Immunologic

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Interval History

- Documents patient's HPI & any changes occurring *since a previous inpatient admission if patient is readmitted within 30 days after discharge for the same condition*
- Original H&P must be made available in the medical record

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Elements of the Physical Examination

- General Survey
- Skin
- Head, Eyes, Ears, Nose & Sinuses, Mouth & Throat
- Neck
- Chest
- Breasts
- Lungs
- Heart
- Abdomen
- Genitalia & Rectal
- Extremities
- Lymphatics & Blood Vessels
- Neurological
- X-ray & Laboratory

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The Completed History & Physical Examination

- X-ray & laboratory analysis
- Differential diagnosis
- Assessment
- Plan

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Consultation Report

- The Joint Commission
  - Medical records shall contain documentation of consultation reports
- Consult
  - Provision of health care services by a consulting physician whose opinion or advice is requested by another physician
  - The attending physician is usually responsible for requesting consults
- Consultation report
  - Documents consultant's findings & opinion based on physical exam & review of patient records
- Consultant
  - May treat patient
  - May become attending physician

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Physician Orders

- The Joint Commission
  - Responsible physician must authenticate diagnostic orders, therapeutic orders, and verbal orders within a time frame specified by the facility
- Medicare Condition of Participation
  - All physician order entries must be legible, complete, dated, timed, and authenticated by the prescribing practitioner

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Types of Physician Orders

- Discharge order
- Routine order
- Standing order
- Stop order
  [or Automatic Stop Order]
- Telephone order
- Transfer order
- Verbal order
- Voice order
- Written order

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Progress Notes

- Document course of patient's illness, response to treatment, and status at discharge
- Facilitates communication
- Frequency of documentation based on patient's condition

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Types of Progress Notes

- Admission note
- Follow-up note
- Discharge note
- Case management note
- Rehabilitation Therapy progress note
- Respiratory Therapy progress note
- Pre-Anesthesia evaluation note

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Anesthesia Record

- The Joint Commission
  - Require documentation of a preanesthesia/pre-sedation assessment
  - Require documentation of monitoring during moderate or deep sedation
  - Patient must be assessed immediately after recover from moderate or deep sedation
- Medicare Conditions of Participation
  - Must document preanesthesia evaluation by individual qualified to administer anesthesia within 48 hours prior to surgery
  - Must maintain an intra-operative anesthesia record
  - Post-anesthesia evaluation document required of individual who administered anesthesia no later than 48 hours after surgery

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Operative Record

- The Joint Commission
  - Surgeon must document prior to surgery: history, physical exam, lab & x-ray exams, preoperative diagnosis, and authenticate document
  - All diagnostic and therapeutic procedures must be documented in the patient record
  - Operative and high-risk procedures must be dictated upon completion of procedure and before patient is transferred to the next level of care
    - If the surgeon accompanies patient from the OR to the next level of care, the report can be dictated in the new area of care
    - If a full operative note cannot be entered immediately into the patient's record, the surgeon may write a progress note before patient is transferred to next level of care, and full report must be dictated within the timeframe established by the hospital
- Medicare Conditions of Participation
  - A complete H&P must be in medical record prior to surgery
  - If the report is not available, the responsible physician must document a statement to that effect along with a complete admission note

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Outpatient Prospective Payment System (OPPS) for Major and Minor Procedures

- Centers for Medicare and Medicaid Services (CMS)
  - Categorize procedures codes as major or minor procedures
  - Assign status indicators to each procedure code
- Major procedures (e.g., carpal tunnel repair, cervical diskectomy, lumbar fusion)
  - May require a hospital stay
  - Usually takes a longer time and is riskier
  - Anesthesia is usually required
- Minor procedures (e.g., trigger point injection, epidural)
  - Usually performed in less than 5 minutes
- Endoscopies are classified as a distinct group regardless of duration

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Pathology Report

- The Joint Commission
  - Requires documentation of an authenticated, dated report performed by pathologist
  - Pathologist is responsible for documenting a descriptive diagnostic report of gross specimens received and autopsies performed

Post Anesthesia Care Unit (PACU) Record

- The Joint Commission
  - Patient's postop status must be evaluated immediately after the procedure and/or after moderate or deep sedation
  - Patient must be evaluated on admission and discharge from PACU
  - A qualified licensed independent practitioner must discharge patient from the PACU or hospital according to criteria approved by hospital

Ancillary Reports

- The Joint Commission
  - Patient's medical records must include reports of pathology and clinical laboratory exams, radiology and nuclear medicine exams, anesthesia records, and any other diagnostic or therapeutic procedures
  - Requests for ancillary testing must include the study requested and appropriate clinical data to aid performance of procedure requested
  - All ancillary reports must be filed in the patient's records as soon as an interpretation has been made (usually within 24 hours)

Types of Ancillary Reports

- Laboratory
- Radiology
- Electrocardiogram
- Electroencephalogram
- Electromyogram
- Transfusion record

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Nursing Documentation

- The Joint Commission
  - Requires documentation of a nursing assessment, nutritional screening, and a functional screening within 24 hours after inpatient admission
- Types of nursing documentation
  - Nursing care plan
  - Nurses' notes
  - Nurse discharge summary
  - Graphic sheet
  - Medication Administration Record (MAR)
  - Bedside terminal system

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Obstetrical & Neonatal Reports

- Obstetric and neonatal records contain unique forms
  - Obstetrical record is the mother's record
  - Neonatal record is the baby's record
    - APGAR scores must be documented

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Autopsy Report

- Medicare Conditions of Participation
  - Medical staff should attempt to obtain autopsies in all cases of unusual deaths
  - Hospital must define mechanism for documenting permission to perform autopsy
  - Must have mechanism for notifying the attending physician when an autopsy is being performed

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Question (Select correct answers)

A discharge summary, also known as a _____, documents the patient's hospitalization, including reason(s) for hospitalization, _____, and condition at discharge.

1. **Level of consciousness**
2. **Procedures performed**
3. **Clinical resume**
4. **Ancillary report**

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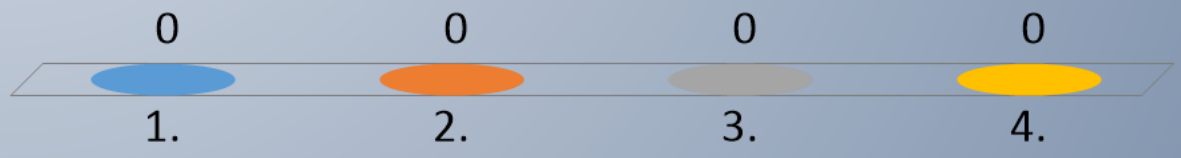
Question (Select correct answers)

If a patient is readmitted within _____ days after discharge for the same condition, a(n) _____ can be completed to document the patient's history of the present illness and any pertinent changes and physical findings that occurred since the previous admission.

1. **Interval history**
2. **Fifteen**
3. **Past medical history**
4. **Thirty**



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Question (Select correct answers)

A consulting physician, as part of the consultation process, is responsible for reviewing the patient's record, _____, documenting pertinent findings, and providing _____ and/or opinions to the referring physician.

1. **Thoughts**
2. **Family opinions**
3. **Physical examination**
4. **Findings**

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Clinical Data in Outpatient Medical Record

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Hospital Outpatient Record

- Definition
  - Medical or surgical care that does not include an overnight hospital stay (and not longer than 23 hours, 59 minutes, 59 seconds)
- The Joint Commission
  - By third visit, patient medical record must contain a summary that lists significant diagnoses and conditions, significant operative and invasive procedures, allergic drug reactions, and medications
- Medicare categorizes emergency room services as hospital outpatient care
- Outpatient records include:
  - Patient registration form similar to inpatient face sheet
  - Can also include ancillary reports, progress notes, physician orders, operative reports, pathology reports, nursing documentation, etc.
- Short-stay record

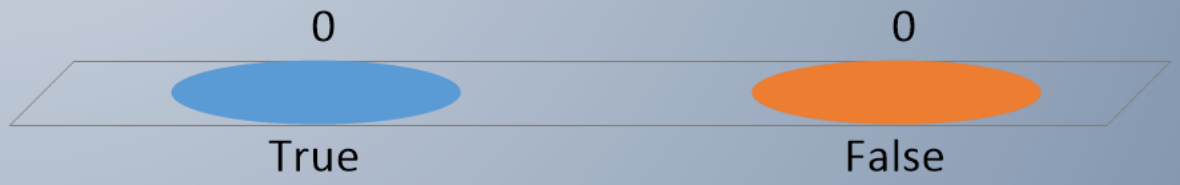
Uniform Ambulatory Care Data Set (UACDS)

- UACDS is minimum care data set collected on Medicare and Medicaid outpatients.
- Current UACDS data elements:
  1. Patient (person receiving health care services)
  2. Date and time of encounter or service
  3. Practitioner (e.g., physician, nurse practitioner, physician's assistant)
  4. Place of service
  5. Active problem(s)
  6. Service or procedure provided

Question (True / False)

The Joint Commission standards require that by no earlier than the fourth ambulatory visit the patient record of a patient who receives continuing ambulatory services must contain a summary list that documents the significant diagnosis and conditions, procedures, drug allergies, and medications.

1. **True**
2. **False**



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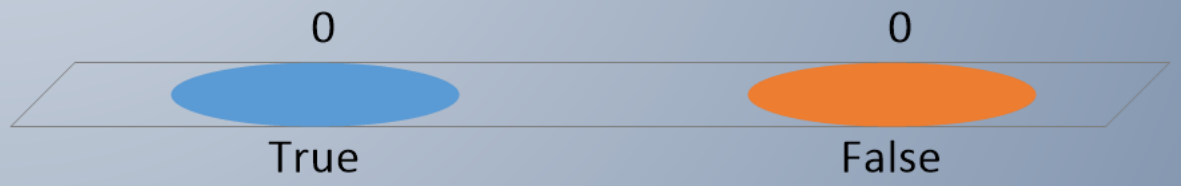
Question (True / False)

Inpatient care can be defined as medical or surgical care that does not include an overnight hospital stay.

1. **True**
2. **False**



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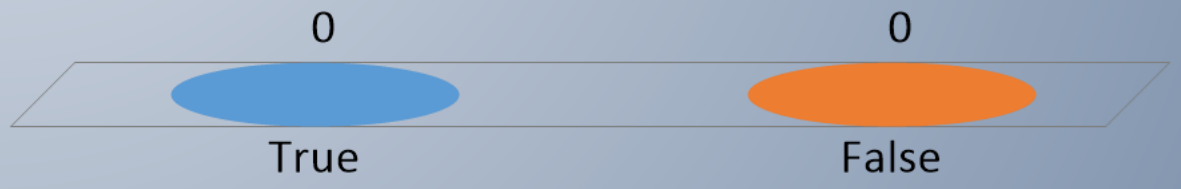
Question (True / False)

Medicare categorizes emergency room services as hospital outpatient care for reimbursement purposes.

1. **True**
2. **False**



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Office Medical Record

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Encounter Form (Superbill or Fee Slip)

- Captures charges generated during an office visit
- Consists of a single page that lists common services

Summary

- Medical record includes documentation about care and treatment
- Each report (paper) and every screen (HER) must include patient name and identification number as well as health care facility's name, address, and telephone number
- Every patient record entry must be dated and timed
- Providers have responsibility to ensure compliance

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Summary

- Hospital inpatient record includes administrative data
  - Demographic, financial, socioeconomic gathered on admission
  - face sheet, advance directives, informed consent, patient property form, birth certificate, & death certificate
- Inpatient record also includes clinical data
  - All health car information obtained about patient's care & treatment
  - ED record, discharge summary, history and physical exam, consultations, progress notes, nurses' notes, and so on

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Summary

- Outpatient medical record documents
  - Diagnostic, therapeutic, & rehabilitation services
  - May use short stay record to document ambulatory surgery cases

- Physician office medical record
  - Patient registration information, a problem list, a medication record, progress notes (including H&P), ancillary reports and results, & office surgery reports
  - May use encounter form (superbill or feel slip) to capture charges during office visit

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