

Medical Records Guide

Introduction

Medical records are discussed in eight parts:

- Development of Medical Records and Accreditation
- Contents of the Hospital Medical Records
- Coding
- Medical Records – Other Than Hospitals
- Medical Records – Mental Health
- Laws and Regulations
- Medical Records and Health Care Plans
- Legal Issues with Medical Records

Development of Medical Records and Accreditation

Historical

Early medical records were begun so as to measure plagues, epidemics and even hostile attacks from enemies. In the 1890's, organized hospitals kept admissions and discharge records. Massachusetts General Hospital has a record of an admission going back to 1821; such records are useful for case research and statistics.

During the mid-1880's proprietary medical schools were more factories than schools. In the early 1900's, professionally acceptable medical schools were begun.

In the successive decades, many improvements in standards of professionalism were seen:

- American College of Surgeons was formed 1913; this group spearheaded the movement to maintain more comprehensive and improved medical records.
- Gradually, standardization was replaced by accreditation.

Accreditation of Medical Institutions

These groups are now devoted to accreditation in one or more ways:

- Joint Commission on Accreditation of Healthcare Organizations. This is sponsored by the American Hospital Association, the American Medical Association, the American College of Surgeons, the American College and the American Dental Association.
- The Joint Commission has numerous areas of accreditation for which standards and/or manuals are published.
 1. Accreditation Manual For Hospitals
Acute Care
 2. Consolidated Standards Manual
Non-acute mental, drug abuse facilities, etc.
 3. Long-Term Care Standards Manual
Nursing care, primarily
 4. Hospice Standards Manual
Hospice care
 5. Standards for the Accreditation of Home Care
Home care
 6. Ambulatory Health Care Standards Manual
Ambulatory care (outpatient and ambulatory surgery)
 7. Managed Care Standards Manual
Managed care

In addition to the accreditation above-cited, there are several specialty groups with accreditation standards:

- *Osteopathic Hospitals*
The American Osteopathic Association has its own hospital accreditation requirements.
- *Rehabilitation Facilities*
The Standards Manual for Rehabilitation Facilities is sponsored by these organizations:
 1. American Hospital Association
 2. American Occupational Therapy Association
 3. Goodwill Industries of America
 4. National Association of Jewish Vocation services
 5. National Easter Seal society
 6. United Cerebral Palsy Association.

In addition to private accreditation efforts, the federal government influences standards by being able to deny government benefits to substandard facilities. The primary federal agency is the Department of Health and Human Services. Major functions within this agency which influence medical care standards are:

- Social Security Administration
- Centers for Medicare and Medicaid Services.
- Public Health Services
- National Center for Health Statistics
- National Center for Health Services Research
- Centers for Disease Control
- Food and Drug Administration
- National Institutes of Health
- Peer Review Organizations.

The states also exercise influence through their Medicaid and public health statutes.

Review of Health Care Providers

These are the providers:

- Hospitals
- Ambulatory Care Facilities
- Long Term Care Facilities
- Physicians (Medical and Osteopathy).
- Dentists
- Nursing (RN, LPN, e.g.)
- Chiropractors and Chiropodists and Optometrists.
- Pharmacists

- Allied Providers (Audiologists, physical therapists, e.g.).

Review of Health-Related Organizations

These are the major health-related organizations:

- American Medical Association
- American College of Surgeons
- American College of physicians (Internists)
- American Hospital Associations
- World Health Organization
- American Medical Record Associations.

Medical Records

Background

While often used interchangeably, health records and medical records are different.

- *Health Records*
Broad. Include birth, immunization, physical examination results, etc.
Records are disjointed. No privacy rules apply.
- *Medical Records*
Narrow. Includes details pertinent only to physical and mental conditions;
composed by and used by providers. The records are owned by the providers.
Strict privacy rules apply.

Medical records have a variety of uses:

- Patient Care Management
- Quality Review
- Claim Filing
- Legal Interests of the Parties
- Education
- Research
- Public Health
- Entrepreneurial by Providers.

The medical records are important to many people:

- Patient – better care
- Provider – few care-giver difficulties

- Profession – increased knowledge
- Third Party Payers – better financing practices.

A fairly large number of persons have direct or indirect responsibility for the medical records:

- Facility management
- Facility medical records department
- Attending physician.

Medical Record Profession

In 1928, the American Medical Records Association was founded to promote the maintenance of medical records as a profession. The Association functions as a true professional association including meetings, a code of ethics, etc. This Association promotes the profession of medical records to a high level.

Contents of the Hospital Medical Records

Overview

To be accredited by the Department of Health and Human Services for Medicare purposes and by the Joint Commission on Accreditation of Health Care Organizations, a hospital must maintain these records:

- Admission Report
- Consent to Treatment Statements
- Attestation Statement (Attending Physician's Statement)
- Medical History
- Physician's Orders
- Report of Physical Examination
- Progress Notes
- Pathology Reports
- Radiology Reports
- Consultation Reports
- Anesthesia Record
- Operative Report
- Nurses' Notes
- Vital Signs Graphics
- Medication Sheet
- Laboratory Report
- Physical Therapy Evaluation
- Respiratory Therapy Evaluation
- Special Reports (Obstetrics, Nursery)
- Discharge Reports.

The records, in one form or another, must be kept for all admissions (inpatient, outpatient, home health, ambulatory, emergency, etc.).

Admission Report

The content of the Report is as follows:

- *Vital Statistics.* (Age, sex, race, name, address, Social Security Number, marital status, insurance, employer, occupation, place of birth, religion, telephone, e.g.).
- *Facts Relative Admission.* (Attending physician, date and time of admission, room number, admitting diagnoses, anticipated procedures e.g.).

The Admission Report must be signed by the attending physician. Note: the Admission Report, upon completion of certain items of additional information becomes the Discharge Report.

Admission Report

The attending physician statement - or Attestation Statement - is a requirement of Medicare. It may be separate or it may be incorporated as part of the Admission Report. The Attestation contains information needed by Medicare to determine DRG reimbursements. The items of information on the Attestation Statement are these:

- Vital Statistics (Name, Birth Date, Age, Sex).
- Hospital Stay Information (Patient Number, Medical Record Numbers, Dates of Admission and Discharge, Attending physician, Type of Discharge).
- Diagnoses (Admitting, Principal, Secondary and Procedures).
- DRG Data (Actual and Average LOS, Outliers, Actual and DRG (charges)).

The Attestation Statement would not be completed for a non-Medicare Patient.

Consent to Treatment Statement

This statement is usually incorporated as the backside of the Admission Statement and is executed by the patient. The statement generally puts the patient under the control of the hospital for its care (general care, nursing etc.) and under the control of the attending physician for such physician's care (medical and surgical procedures). The statement gives the release of the information, as may be needful, to family, insurance companies and employers. Also it gives the patient its rights and expectation as regards the security of valuables and makes the patient squarely responsible for the payment of the hospital bill, assignment notwithstanding.

Special Consent Statement

Special consent statements are required for any non-routine diagnostic or therapeutic procedure. See the separate subsection herein entitled Legal Aspects of Consent Statements.

Medical History

Medical History is a significant part of one's medical record. A broad outline of a medical history could include these items:

- Chief complaints
- Present illness

- Past medical history
- Personal habits, social-economic issues
- Family history
- Specific health questions.

Report of Physician Examination

The examination should include all body systems. Results of tests results are to be made part of the examination (EKG, e.g.)

Physician's Orders

Such orders may be written or verbal. These are the *marching orders* of the attending physician as regards tests, medication, treatment, etc. Such orders should be currently dated and authenticated. Standing orders are acceptable in certain circumstances but are discouraged by the hospitals. No hospital discharges are possible unless the attending physician so authorizes. Leaving a hospital without a medical authority is possible but has legal complications favorable to hospital. Verbal orders are acceptable within limits. Verbal orders must be authenticated with a signature within twenty-four hours. The physician's orders should indicate any drug allergies.

Progress Report

The Progress Report is also called the Physician's Notes and relates to the patient's illness, treatment and status at discharge. Where the Progress Report is integrated, the notes of other treating physicians will be included therein. Examples: therapists, nurses, etc. The Progress Report will be in three parts:

- Admission Statement
- Progress Statement
- Discharge Statement.

Specialist's Progress Notes

A fairly large number of specialty progress notes are also made part of the Medical Record.

- Pathology
- Radiology
- EKG and EEG
- Electromyogram
- Consultation
- Anesthesia
- Operative

- Recovery Room
- Nursing
- Therapists (physical or Respiratory).
- Laboratory.

Miscellaneous

A number of miscellaneous items find themselves into the patient's Medical Record:

- Graphic sheet (Vital Signs)
- Medication Worksheet
- Social Worker's Report (if any).

Maternity Records

Because of the special nature of the Maternity Unit of the facility, specialized records are needed.

- Specialized Physical Examination (Antepartum Record)
- Labor and Delivery Room Record
- Postpartum Record
- Infant Data (birth history, ID, profile, physical examination and medical progress of infant).

Organization of Medical Record

The organization may be by source, by problem or integrated.

Source. The order is found as the care or treatment was provided.

Problem. The order is found as the care or treatment was provided.

Integrated. The order is found by date provided without regard to source or problem.

Nature of the Record

The records should be well documented, well authenticated, readable and timely. Only pre-approved abbreviations are acceptable. Errors and omissions should be corrected, according to standards.

Responsibility For The Record

Most hospitals have a Medical Records Committee to oversee the function and set the guidelines therefore. Physicians, nurses, etc. who do not abide by the rules of good record management may be disciplined.

The person in the hospital responsible for the medical records will deal with the medical providers in these many and significant ways:

- Assisting the medical staff in drawing up policies for medical record content/completion.
- Orienting house staff and new members of the attending staff to the hospital's medical record content and completion policies; manuals be prepared for this purpose.
- Developing procedures to facilitate completion and incomplete records.
- Keeping physicians informed of the number of records requiring completion
- Administering policies uniformly for completion of records
- Providing timely transcription of reports for the medical record
- Supplying data and assisting physicians in conducting research studies
- Presenting educational programs for physicians on documentation requirements which impact on reimbursement.
- Making medical records available for ongoing care of patients
- Developing or revising medical record forms.

Medical Records – Other Than Hospitals

Introduction

There are seven health care facilities which require medical records of a special nature:

- Ambulatory care.
- Nursing care.
- Home care.
- Hospice care.
- Respite care.
- Rehabilitation care.
- Mental Health care.

Each of these special facilities will be briefly discussed, pointing out to the reader what special medical records adjustments are demanded. Only the ambulatory and nursing records are discussed in detail.

Ambulatory Care

In General

Many forms of ambulatory care are seen – extension of an HMO, special hospital outpatient, freestanding ambulatory center. As is well known, cost considerations have driven the ambulatory facility to its present popularity.

Hospital Ambulatory Care

Hospital-provided care is of these forms:

- Special Services (laboratory, therapy, radiology, e.g.)
- Outpatient Services (basically walk-in-care)
- Ambulatory Surgery
- Emergency Room.

Free Standing Ambulatory Care

These may be sponsored by an HMO, PPO or a group of physicians. The facility may be limited (emergency-center) or may be an ambulatory surgical center.

Employer-Sponsored Care

A business, a university, e.g., may maintain its own health care facility.

Ambulatory Care Records

The Joint Commission requires that certain records be maintained at a minimum. The difficulty is that the staffing of the typical ambulatory facility is not in the position to maintain the quality records which should be found on a hospital setting. There are several features of ambulatory care which demands greater attention to quality medical records, however.

- High number of life or death situations are dealt with which demand careful documentation.
- Need for ambulatory facility to network with other facilities as regards medical information.

These are the records which normally must be kept:

- Emergency Room Record.
- Outpatient General Record.

Emergency Room Record

For each record of a hospital emergency room there must be an Emergency Room Record.

- *Vital Statistics*. Name, age, sex, address, social security number, telephone, employer, insurance plan (whether occupational accident or not). Medicare status, family physician, marital status, arrival date and time.

- Brief History of Accident or Illness. Details of accident or illness, allergies, last tetanus, present prescription drugs being taken, notification to police or family. This information must be signed off by the admitting nurse.
- Physician's Report. This is a family exhaustive appraisal by the attending physician – arrival condition, vital signs, findings, diagnosis, treatment, disposition, condition at discharge, instructions. This information must be signed off by the treating physician.
- Charges. Breakdown of services and charges which includes x-ray, laboratory and therapy, if any.

Emergency Room Records are stored in chronological order.

Outpatient General Record

A hospital will maintain a separate record for its outpatient visits. This form will be made up of these sections:

- Vital Statistics
- History – Physical Examination
- Personal – Social Information
- Reports of X-rays, Laboratory
- Physician and Nurses Notes
- Treatment and/or Home Follow-up.

Free Standing Ambulatory Care Facility

The Joint Commission's Ambulatory Health Care Standards Manual sets the record requirements for ambulatory surgery centers, emergi-centers, HMO emergency rooms, private group practices and neighborhood health centers. The information contained in these records is essentially that found in the Emergency Room Record.

Quality of Records

The Joint Commission expects the ambulatory facility to maintain quality records.

- Efficiency and accuracy
- Provision to follow up on missed appointments
- Timely review of tests and studies
- Follow up care for ambulatory surgery patients
- Patient prescription drug profiles
- Evaluation of patients prescription drug regimen
- Blood usage review where transfusion may be involved
- Follow up compliance for radiation therapy
- Records understandable to average person.

Nursing Facilities

In General

While most nursing facilities are for profit, the statutes of most states require that the administrator be licensed by the state. Each patient in a nursing facility must have an assigned attending physician. While the facility administrator has the overall responsibilities, it is the nurses who provide the majority of the facility's services:

- Therapy (occupational, physical, respiratory).
- Dietary
- Daily Care
- Administering medications.

The nurses include: registered and practical nurses and aides.

Medical Records

These are the principal nursing facility records:

Vital Statistics. The usual age, sex, etc. data.

Patient Transfer Record. This record states the major diagnosis, diet-drug-therapy requirements, allergies, vital signs, etc. This form is not a permanent one but rather one that is transitory when a patient is transferred.

Patient Information Record. This record gives an extensive profile of the patient's health status and is extended to behavior, mental condition, communication ability and social-related information. This record also serves as the admission and discharge record.

Miscellaneous Record

These would include the following records:

- Care Plan
- Discharge Plan
- Orders for Care
- Pharmacy Consultation Review
- Progress Notes
- Social Service Reports
- Special Reports (x-rays, laboratory, e.g.)
- Physician Discharge Summary.

In addition, there are numerous incidental reports which are more common with nursing facilities than with acute care facilities:

- Legal papers (Power of Attorney, e.g.)
- Financial agreements, handling of valuables, e.g.
- Release of liability, consent for autopsy, living wills, insurance papers
- Death certificates

- Accident or Incident Reports (these are more common in a nursing facility).

Administration of Records

Some person in the nursing facility with authority must be responsible for the facility's medical records. When supervising the Medical Records, these functions must be attended to:

- Data must be collected timely and accurately.
- Date must be maintained with quality as a goal.

Release of Information

The Medical Records are confidential information. The privacy and confidentiality rules are dictated by statements and vary from state to state. No medical data should be released except with proper authorization.

Medical Records – Mental Health

Background

The creation of the National Institutes of Health in 1946 and the passage of the federal Community Mental Health Centers Act of 1963 gave form and substance to the nation's present high standards of mental health care. Medicare has for many years provided benefits for mental health care.

In 1972, the Joint Commission on Accreditation of Health Care Organization set standards for specific care:

- Child and adolescent psychiatric care
- Drug and alcohol abuse and rehabilitation
- Care of developmentally disabled.

There is a standard manual called the Consolidated Standards Manual to be followed by accredited providers.

Content of Mental Health Record

The basic thrust of the records is to document the valuation, treatment and course of the illness.

Evaluation

- Physical

- Emotional and Behavioral
- Social
- Recreational
- Legal
- Vocational
- Nutritional.

Treatment

- Content of plan (goals and objectives)
- Treatment modalities
- Frequency of documentation
- Progress notes
- Discharge and follow-up care
- Special therapies (seclusion, restraint, shock, e.g.)
- Record documentation.

Review

This is essentially the progress record.

Miscellaneous

Utilization Review

The utilization process is complicated because of the confidentiality factor. Factors normally considered when performing a utilization review are these:

- Appropriateness and clinical need for admission
- Hospital discharge factors
- Continued care or rehabilitation
- Needed support services.

Release of Information

Right to privacy must be honored. The federal rules related to drug and substance abuse must be carefully noted. These federal rules are stringent and put special restraints on such care and treatment records. See CFR §42, Part 2.

Consents

All patient consent statements become part of the patient's record. There are state laws which permit certain family members to give consent where the patient is unable to do so.

Codings

Current Procedure Terminology (Cpt)

The current version is the CPT-4 which is incorporated in and made part of the HCFA Common Procedure Coding System. The CPT codes deal only with diagnostic and therapeutic procedures.

The CPT is of five sections.

- Medicine
- Anesthesiology
- Surgery
- Radiology
- Laboratory.

International Classification of Diseases

The most recent version is the 9th which has codings for clinical modifications. Hence it has named ICD-9-CM. The ICD material is presented in these books:

Book 1 – Diseases listed numerically

Book 2 – Diseases listed alphabetically

Book 3 – Procedures both numerical and alphabetical.

Medical Records and Health Care Plans

Such records must be accurate and available because of the assignment of benefits found with most provider claims. The need for good records has increased greatly because of heightened interest in cost containment. In the early days of caregiving, charges were based upon ones' ability to pay with religious or charitable organizations making up for any losses. Gradually, these practices went out of favor due in part to:

- Growth of employer-sponsored plans
- Consumer expectation of medical care
- Cost and need of malpractice insurance
- Increase in medical technology
- Expansion of federal medical plans (Medicare and Medicaid, primarily and CHAMPUS are the federal government employees plans secondarily)
- Prospective Payment Systems (DRG, RBRVS, e.g.)
- Peer Review Systems
- Ambulatory Care
- Managed care programs (HMO, PPO).

Legal Issues With Medical Privacy

Background

The medical record should be viewed as a legal document. Critical to medical records is the matter of confidentiality. In grasping with the legal issues, one must consider these sources of law: statutory, regulatory and court cases.

Why Medical Records Must Be Maintained

State, but not federal, statutes require that medical records must be maintained; even without such statutory mandate, providers would keep such records because of their importance to patient care.

Most state statutes are quoted explicit as to the type and scope of medical records. Federal statutes and regulations do affect certain medical records; however, these are several examples:

- Where hospital is Medicare-reimbursed or Medicaid-reimbursed
- Where substance abuse programs are involved. Importantly, non-governmental governing bodies (e.g., American Hospital Association) have record-maintenance requirements.

Who Owns the Medical Record

The generally accepted legal principle of law is that the institution has claim to its own records; they do not belong to the patient. However, the contents of the records belong to the patient. This is legal principle upon which privacy rules rest.

Who Is Responsible For Generating the Medical Record

Caregivers have the responsibility – at all levels and across all levels of care. For example, nurses, social services, pastoral care – yes; medical students, however – no. The document preparer must sign by name and title (no initials).

Confidentiality of Record

The Code of Ethics of the American Medical Record Association abides strictly by the basic tenets of privacy, while used interchangeably, confidentiality is a special nature of privacy. Not only must privacy guidelines be followed but pains should be taken to keep adequate security on the medical records.

Laws And Regulations

Introduction

State statutes deal with privacy issues but only a select few federal statutes do so. Numerous federal privacy guidelines are available:

- Privacy Act of 1974
- Medicare/Medicaid Conditions of Participation
- Special provider rules
- Substance abuse rules
- Graham-Leach. Bailey Act and HIPAA
- Regulations promulgated by HHS.

The states have privacy rules in these areas:

- Statutes of Standards
- Public health statutes.

Privacy Act of 1974

This statute deals only with federal government hospitals; it has no effect on non-federal hospitals. The statute also created the Privacy Protection Study Commission which recommended a voluntary-type of privacy system.

Condition of Participation

These conditions, mandated by HCFA, require that participating Medicare/Medicaid providers meet certain standards as regards records maintenance. Such providers include long-term care facilities.

Substance Abuse Rules

Federal laws relating to substance abuse records came into being due to the sensitivity of such information. These special rules apply where the facility has any special substance abuse care unit; general medical care is not affected. There are stern monetary penalties for non-compliance.

Basically the rules place additional screens, and checks/balances before such record contents are released.

Recent Legislation and Regulations

Because of the extensive provisions of the recent federal laws and regulations, a separate section on Privacy and Confidentiality is provided.

Standard State Statutes

The National Conference of Commissioners on Uniform State Laws has promulgated a standard state privacy statute; the name of the model act is the Uniform Healthcare Information Act. The Act is supported by the American Medical Association.

The main thrust of the Uniform Act is this:

- Medical records may be released only with the patient's consent.
- A subpoena may be required to release medical information in a legal context.
- Patients have access to their own records.

The Act sets forth stern penalties for noncompliance. Of great interest to third party payers is the provision of many of the state statutes which deals with fraud and health care records.

The statutes of some states prevent a provider from testifying for or against a patient without such patient's consent. These are called *privileged communication* statutes.

Public Health Laws

Certain medical episodes must, by law, be reported: gunshot wounds, births, deaths, e.g. such events in some states, include malignant tumors. The reporting burden is generally on the provider.