School Of Osteopathic Medicine (SOM)
Practice Operations Procedure
Title: The Legal Medical Record – Content and Requirements

I. BACKGROUND:

The School of Osteopathic Medicine (SOM), Faculty Practice Plan is a multi-specialty group practice. Patients seen by clinicians within the group practice are managed collaboratively and changes in clinical management by one clinician should be available to all clinicians caring for that patient.

Legal medical records are records of care in any health-related setting used by healthcare professionals while providing patient care, or for administrative, business, or payment purposes. The legal medical record contains individually identifiable data, stored on any medium, and collected and directly used in documenting healthcare or health status. The legal medical record is a subset of the entire patient database, which serves as the legal business record for the practice.

The roles of the legal medical record are to:

- support decisions made in a patient's care
- support the revenue sought from third-party payers
- document the services provided as a legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions

The legal medical record at SOM is a hybrid of paper-based and electronic/computer-based databases. Moving forward, the sole medium for new clinical documentation will be the GE-EMR. The determining factor in whether something is to be considered part of the legal medical record is not where the information resides or the format of the information, but rather how the information is used and whether it is reasonable to expect the information to be routinely released when a request for a complete medical record is received.

II. PURPOSE:

This procedure establishes standards for the requirement of entries in the medical record and defines the contents of the legal medical record.

III. ACCOUNTABILITY:

Dean–SOM; Clinical Dean-SOM; SOM-Department Chairs; SOM-Business Administrators; EMR System Administrator.

IV. OBJECTIVE:

It is the objective of SOM that a complete, legible medical record shall be maintained for each individual who receives clinical care from a provider within the practice. All healthcare services provided shall be properly documented in the patient's medical record. All entries, forms, and reports shall be signed by the appropriate provider.

Currently, the Medical Record is considered a *hybrid* record, consisting of both electronic and paper documentation. Documentation that comprises the Medical Record may physically exist in separate and multiple locations in both paper-based and electronic formats.

Once a practice has been transitioned to the EMR, the legal record will be the EMR and all documentations shall be made and maintained in this medium.

Paper records from prior to the EMR transition shall be retained according to UMDNJ record retention requirements.

V. DEFINITIONS:

Medical Record – Refers to the record kept on all patients treated within SOM, no matter what medium it is created or maintained in.

Outside Test Results – Results of diagnostic tests ordered and performed outside of SOM.

Outside Records - Records of care provided outside of SOM.

GE EMR – The electronic system used as the medical record repository for SOM.

Designated Record Set – A group of records that include protected health information(PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity (e.g. – SOM) for each individual that receives care from a covered individual or institution. This includes medical and billing records, and any other records used by the provider to make decisions about an individual.

Patient Generated Records – Any record generated by the patient that is made part of the medical record and used by the provider for decision and care management.

VI. PROCEDURE:

The GE EMR is designed to be used at the point-of-care to support timely access and retrieval of information, accurate and complete capture and documentation of information, clinical decision-making, and communications with all stakeholders in the care process. Once a practice has transitioned to the EMR, all records and documentation are to go into the EMR. Nothing new shall be added to the paper chart. Use of the EMR should support all documentation requirements of "meaningful use" as mandated by the American Recovery and Reinvestment Act.

A. Entries –
- All documentation and entries in the Medical Record, both paper and electronic must be identified with the patient's full legal name and a unique Medical Record Number (MRN). Each page of a double-sided or multi-page form must be marked with both the patient's full legal name and the unique MRN since single pages may be photocopied, faxed or imaged and separated from the whole.
- At the minimum, EMR documentation is to include:
  - Office Visit Note
  - Updating of Medication List, Allergies, Problem List, Vital Signs, any other elements required by law or billing requirements and any data selected by the Group for Quality and Outcome Assessment.
- For all patient visits documented in the EMR, a visit note should be started at the beginning of the patient visit.
- All prescriptions and refills for medication are to be made through the EMR. ***Note, current usage of E-Prescribing are through "other" systems.***
- All Diagnostic tests should be ordered through the EMR.
- All telephone communication with patients are to be documented as a Phone Note.
- Entries are to be made as soon as possible after the care is provided, or an event or observation is made. An entry shall never be made in advance. Pre-dating or backdating an entry is prohibited.
- Entries must be accurate, relevant, timely, and complete.
- All entries shall be made by the person providing the health care service or making the observation.
- All entries should be signed immediately after they are made. If this is not possible, Visit Notes shall be completed and signed within 7 days of the visit and for all other documentation, the time for authentication shall not be longer than 30 days after the entry is made. See **Attachment A** for escalation procedure.

B. Outside Test Results –
Results of tests ordered by providers are made part of the permanent Medical record in a number of ways – electronic interface, paper to paper chart, and paper to scan for inclusion in the EMR.
- All outside test results must be authenticated by the responsible provider (or designee) prior to being made an official part of the medical record.

C. Outside Records –

Records coming in from outside will be made part of the Legal Record as delineated by the patient's provider. All records are to be date stamped when received and initialed to signify that they have been reviewed and are to be made part of the legal record.

D. Patient Generated Records – Questionnaires and any other patient recordings that are presented to the provider for review will need to be dated and signed by the provider. These will then become part of the permanent medical record. If the practice is using the EMR for documentation, these records will be scanned in after the visit, for inclusion in the permanent medical record. If the document has not been dated and signed prior to scanning, it will be routed to the physician for signing electronically.

E. Contents
The legal medical record shall include, at a minimum, the following items (if applicable):

a) Name
b) Address on intake
c) Age
d) Sex
e) Race
f) Marital Status
g) Legal Status
h) Name, address and telephone number of person or agency responsible for patient ** Not mandatory**
i) Name of patient's primary provider ** Not mandatory**
j) Consent forms for care, treatment, and research
k) Advance directives
l) Allergy records
m) Medical History including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients, a neonatal history
n) Physical examination
o) Consultation reports
p) Orders, including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services.
q) Progress notes, including current or working diagnosis (excluding psychotherapy notes).
r) Psychology and psychiatric assessments and summaries(excluding psychotherapy notes)
s) Nurses' notes , which include, but not be limited to, the following:
    a. Nursing assessment including nutritional, psychosocial, and functional assessments
    b. Concise and accurate record of nursing care administered
    c. Record of pertinent observations including psychosocial and physical manifestations and relevant nursing interpretation of such observations.
    d. Name, dosage and time of administration of medications and treatment. Route of administration and site of injections shall be recorded if other than by oral administration.
t) Graphic and vital sign sheet
u) Medication records
v) Results of all laboratory tests performed.
w) Results of all imaging studies performed.
x) Other diagnostic studies.
y) Problem list.
z) Anesthesia record, including preoperative diagnosis, if anesthesia has been administered.
aa) Operative and procedure report including preoperative and postoperative diagnosis, description of findings, technique used and tissue removed or altered, if surgery was performed.

bb) Pathology reports.
cc) Written record of preoperative and postoperative instructions.
dd) Patient education or teaching documents
ee) Care Plans
ff) Records received from other healthcare providers, if they were relied on to provide healthcare to the patient.
gg) Telephone Encounters

The following documents are not part of the legal medical record:

a) Abbreviation and do not use abbreviation lists
b) Audit trails related to the EMR
c) Authorization forms for release of information
d) Birth and death certificate worksheets
e) Correspondence concerning requests for records
f) Databases containing patient information
g) Event history and audit trails
h) Financial and insurance forms
i) Incident or patient safety reports
j) Indices(disease, operation, death, etc)
k) Institutional review board lists
l) Logs
m) Patient-identifiable claims
n) Patient-identifiable data reviewed for quality assurance or utilization management
o) Protocols and clinical pathways, practice guidelines, and other knowledge sources that do not imbed patient data
p) Registries
q) Staff roles and access rights
r) Work lists and works-in-progress
s) Carbon copies or blank forms
t) Financial reports
u) Patient schedules

VII. OTHER RELATED POLICIES

A – Retention of Records and Destruction of Records
B – Release and Disclosure of Patient Protected Health Information
C – Scanning and Indexing of Records

VIII. ATTACHMENTS:

A- Procedure for dealing with providers who allow > 30 days authentication of signed documentation. The Escalation Procedure.

IX. DISTRIBUTION:

X. APPROVAL:

Signature / Title — Date

XI. PROCEDURE RESPONSIBILITY: IN COORDINATION WITH:

XII. REFERENCES:

XIII. REVISION:

XIV. DATES:

Origination: September, 2010
Last Review: _____
Next Review: _____

School Of Osteopathic Medicine (SOM)
Title: Attachment A for
The Legal Medical Record – Content and Requirements

I. BACKGROUND:
The timely acknowledgement of clinical entries into the legal medical record by SOM clinical staff is a prerequisite for delivering quality care, obtaining fair revenue collection from 3rd party payers for services rendered and providing documented legal testimony of SOM services delivered in response to our patient's health condition at the point of care.

II. PURPOSE:
To establish a standardized protocol for the enforcement of The Legal Medical Record Procedure as it relates to signing documents, including those in the Electronic Medical Record (EMR).

III. ACCOUNTABILITY:
Dean–SOM; Clinical Dean-SOM; SOM-Department Chairs; SOM-Business Administrators; EMR System Administrator.

IV. POLICY:
Policy – All clinical documents must be signed within 30 days of the date of service or will be considered "overdue".

V. PROCEDURE:
Staff members with multiple overdue unsigned documents will face disciplinary action as follows:

1. Initially a written warning by the Dean of Clinical Affairs will be sent emphasizing the importance of signing electronic documents in a timely manner.
2. Possible Administrative Leave with Pay.
3. Continued infractions may warrant withholding salary until all documents are signed.

VII. OTHER RELATED POLICIES

A – The Legal Medical Record Procedure

VIII. APPROVAL:

Signature Title

11/8/10
Date

IX. REVISION:

X. DATES:
Origination: September, 2010
Last Review: _____
Next Review: _____