chapter 1

THE MEDICAL RECORD

LEARNING OBJECTIVES

- Understand the components of the medical record
- Understand how medical records are organized
- Review record retention recommendations
- Review examples of the components of the medical record
- Successfully complete end-of-chapter exercises

DEFINING THE MEDICAL RECORD AND THE ROLE OF THE MEDICAL RECORD ADMINISTRATOR

The medical record is a graphic record that is created for each patient at his or her first medical office visit. In the hospital, the medical record is created when the patient is admitted for services. The medical record serves a variety of purposes and is essential to the proper functioning of the medical practice—especially in today's complicated health care environment. The medical record is a key instrument used in planning, evaluating, and coordinating patient care in both the inpatient and the outpatient settings. The content of the medical record is essential for patient care, accreditation (if applicable to the practitioner), and reimbursement purposes. Your medical records (charts) should detail information pertinent to the care of the patient, document the performance of billable services, and serve as a legal document that describes a course of treatment. Periodic audits, whether internal or external, ensure that the record adequately serves these purposes and meets federal and state regulations.

Medical record employees are responsible for safeguarding the security of the patient record and maintaining confidentiality. Normally, one person is held responsible for overall supervision and maintenance of the medical record. It is the responsibility of each office employee, including the physician, to safeguard and protect the medical record. Safeguards should be implemented within the medical office to keep medical records secure and to prevent patients, vendors, or outside visitors from seeing a patient medical record.

The medical record administrator is responsible for filing patient information, eg, laboratory reports and test results, in the medical record. He or she is also responsible for knowing medical insurance contract

requirements, legal requirements pertaining to privacy and confidentiality of the patient. The medical record administrator may be a clinician, billing manager, coder, or anyone assigned the responsibility in the medical office. The medical record administrator is also responsible for making sure the medical record is complete and that dates and signatures are evident in the medical record. Security and confidentiality of the medical record are another key responsibility. Medical records should be kept in the office and must be made available without delay. They should be kept in one location with easy access to all authorized personnel.

MEDICAL RECORD ACCOUNTABILITY AND PRIVACY AND RELEASE OF MEDICAL RECORD INFORMATION

Accountability for patient information and maintaining security of the information is an important aspect of a medical record position. The medical record administrator will be responsible for receiving and distributing faxes related to the patient record and distributing patient test results to the physician(s) to review before placing them in the medical record. The fax and/or test result should be attached to the front of the patient's medical record before the chart is given to the provider to review. The provider should date and sign and/or initial the test result, lab report, consultation report, etc, to attest that the information was reviewed. Once the physician has initialed the information, he or she becomes accountable for the information reviewed.

With the change in the Health Insurance Portability and Accountability Act (HIPAA), privacy and patient confidentiality are an important part of the medical record. The employee responsible for the medical record should:

- Appropriately respond to requests for medical records in a timely manner
- Safeguard against improper release
- Ensure that patient confidentiality is protected

Specific parameters concerning consent are as follows:

1. Consent must reference the individual to the covered entity's notice of privacy practices. A consent may not be combined in a single document with the notice.
2. The consent must indicate that the individual has the right to review the notice before signing the document. If the provider has reserved the right to change privacy policy, the consent must state that the notice may change and the method for obtaining the revised notice must be included.
3. If other legal permission is combined on the consent form, it must be separate from the consent for treatment and require separate signatures and dates.
4. The consent may combine other forms of legal permission or state law requirements.

5. Consent must state that the individual has the right to request restrictions on the use and disclosure of his or her personal medical information, but it must also state that the covered entity may refuse the request.
6. Consent may be combined with an authorization so that the patient's privacy may be breached when research involves treatment of the individual. This is the only circumstance when consent may be combined with an authorization.
7. Covered entities (providers of services) must document and retain any consent.
8. If the consent lacks the required elements, the consent is not valid.

COMPONENTS OF THE MEDICAL RECORD

The medical record has many components. Each component of the outpatient medical record will be reviewed with illustrations later in the chapter. At a minimum, the medical outpatient medical record should contain the following:

- Patient identification (patient registration form)
- Assignment of benefits and release of information
- Consent for treatment (evidence of appropriate informed consent)
- Medicare lifetime claim authorization (if applicable)
- Patient medical history (including drug allergies)
- Medication sheet
- Problem list
- Factors that affect learning
- Preventive medicine screenings
- Waiver of Medicare liability (if applicable)
- Invasive procedure consent (if applicable)
- Physical examination (encounter)
- Diagnostic and therapeutic orders
- Clinical observations, including progress notes, consultation reports, nursing notes, and entries by specified personnel
- Laboratory reports (reports of tests and their results)
- Reports of procedures and their results
- Conclusion if terminating treatment, including final disposition, condition at discharge, medications prescribed, and any instructions for follow-up care
- Preventive medicine services (primary care providers)
- Immunization records

The medical record in the physician's office should be consistently organized to allow information to be found promptly. Uniformity of the medical record is a key element in chart organization. Dividers may be used to separate sections of the medical record. For example, a medical record may have the patient registration form, consent for treatment, medication sheet, immunizations, screenings, and problem list on the left side of the chart, with the patient encounters (visit notes), nursing notes, operative

reports, laboratory reports, old medical records, etc, on the right side of the chart.

MEDICAL RECORD ENTRIES

Medical record entries should be accurately dated and authenticated by the provider of service whether it is the physician, nurse practitioner, nurse, medical assistant, or any other health care provider who has access to the medical record. Legibility of recorded information is an important aspect for usefulness of the medical record. The auditor's motto is "not documented, not done," which also encompasses legibility. Pencil and blue ink should be avoided. The majority of documentation in the medical record is in black ink, which is the industry standard. Many states require the identity of the provider, signature, initials, and/or, in some states, a rubber stamp of an original will suffice. Rubber-stamped signatures are not permitted; however, as a substitute for written signatures or initials in many states, so when reviewing medical records, reference state regulations covering signature requirements.

Corrections to the medical record should be made by a single line drawn through the error, with the corrected text entered nearby. Each correction must be initialed and dated by the person who made the error. Review the example below:

Example:

10/20/20xx Sally Jones, RN

Tom, an established patient, is in the office today for follow-up of ~~otitis media~~ *bronchitis.*

All pages of the medical record must contain the date and patient's name. Medical records may be dictated, handwritten, or recorded on a form, typically referred to as a *patient encounter form.* All dictation, handwritten notes, and/or forms must show the date of service (examination and/or procedure) and the identity of the person recording the information. Dictation should also include the date of the dictation and the date of the transcription.

THE PATIENT REGISTRATION FORM

A new patient must complete a patient registration form at the first visit (Figure 1-1), which becomes part of the patient's permanent medical record. The registration form, sometimes referred to as the *patient information sheet,* is used to collect information regarding the patient's demographics. The patient and/or responsible party should complete the patient registration form. This is a legal record that can be used to hold the patient or guarantor (responsible party) accountable for the medical bill and allows the practice to collect payment from the guarantor.

The patient registration form should be updated periodically (at a minimum, once per year) to make sure accurate and updated information is available and to verify insurance information. The following information is normally included on the registration form:

FIGURE 1-1

Patient registration form

PATIENT INFORMATION

Patient name First _____ Middle initial ___ Last _____

Address _____ City _____ State___ Zip code _____

Date of birth _____ Age_____ Sex ☐Male ☐Female Marital status ☐S ☐M ☐W ☐D

Social Security # _____ Phone # _____ Work # _____

Employer _____ Employer's address _____

Friend or relative not living with you _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name First _____ Middle initial ___ Last _____

Address _____ City _____ State___ Zip code _____

Date of birth _____ Age _____ Sex ☐Male ☐Female Social Security # _____

Relationship to patient _____ Home telephone _____ Work # _____

Employer _____ Employer's address _____

Friend or relative not living with you _____ Phone # _____

INSURANCE INFORMATION

Primary insurance _____ Insurance company _____

Insurance company phone # _____ Insurance address _____

Insured name _____ Relationship ☐Self ☐Spouse ☐Dependent ☐Other

ID# _____ Group# _____ Is this an employer group plan? ☐Yes ☐No

If yes, name of employer _____ Insured's employer _____

Employer's address _____ Phone # _____

Insured Social Security # _____ Date of birth _____ Sex ☐Male ☐Female

Secondary Insurance Company _____Phone # _____

Insurance address _____ ID # _____ Group # _____

Insured name _____ Relationship ☐Self ☐Spouse ☐Dependent ☐Other

Is this an employer group plan? ☐Yes ☐No If yes, name of employer _____

Insured's employer _____ Address _____ Phone # _____

Insured Social Security # _____ Date of birth _____ Sex ☐Male ☐Female