

CHILDREN'S HOSPITAL LOS ANGELES MEDICAL GROUP
COMPLIANCE POLICY MANUAL

POLICY	Legal Medical Record Standards for Hospital-Based and Independent CHLAMG Physician Practices
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PURPOSE

To ensure CHLAMG providers follow internal guidelines for the completion of patient medical records that are grounded in federal and State laws and the OIG's Compliance Program Guidelines for Physician Practices.

DEFINITIONS

Medical Record: The medical record is the collection of information concerning a patient and his or her health care that CHLAMG creates and maintains in the regular course of business. This policy addresses only those entries made by CHLAMG members, specifically physicians, nurse practitioners, physician assistants, psychologists, and optometrists for whom CHLAMG granted privileges to bill under the group's National Provider Identifier (NPI).

Legal Medical Record: The legal medical record is a complete collection of documentation of services that medical staff signed and/or authenticated. CHLAMG providers furnish to patients.

Authentication: Authentications is the process that ensures that users are who they say they are. The aim is to prevent people from accessing data or using another person's identity to sign documents without authorization.

Signature: A signature identifies the author who takes ownership of and attests to the accuracy of the information a record entry or document contains.

Macros: Macros allow a provider to record and replay a series of typed characters or other keystrokes (e.g., hot keys, one or more keys at the same time, or one-word commands) in a manner that makes it possible for a provider to quickly document an entire medical note.

MAINTENANCE OF THE MEDICAL RECORD

- A. The Health Information Management Department of CHLA and other acute hospital HIM departments with whom CHLAMG provides contracted services for inpatient, outpatient, and emergency services maintain medical records. Standalone medical practice sites and offices not affiliated with CHLA will maintain separate medical records in a similar manner to that described in the rest of this document.
- B. CHLAMG maintains medical record contents in either paper (hard copy) or electronic format, including digital images, and can include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips and/or a written or dictate summary of interpretation of findings.
 - C. Send original medical record documentation to the HIM department. Clinics or care sites can maintain shadow files, while staff should file the originals in the patient's permanent medical record.,

CONFIDENTIALITY

- A. The medical record is confidential and the law prohibits disclosure without authorization. The circumstances under which CHLAMG may use and disclose confidential medical record information are set forth in the Notice of Privacy Practices and other CHLAMG Compliance and Privacy policies and procedures.

CONTENT

- A. Medical record content shall meet all State and federal legal, regulatory, and accreditation requirements including but not limited to Title 22 California Code Regulations, §70749, §70527, and 71549, and the CMS Condition of Participation 42 CFR §482.24.
- B. All hospital-based clinic records must comply with the applicable hospital's Medical Staff Rules and Regulations requirements for content and timely completion.
- C. Identify all documentation and entries in the medical record, both paper and electronic with the patient's full name and a unique medical record number (MRN). Mark each page of a double-sided or multi-page form with the both the patient's full name and the unique MRN.
- D. Practitioners and staff should document all medical record as soon as possible after they provide care, an event occurs, or they make an observation. Never make an entry in the medical record before rendering a service to the patient. This policy prohibits pre-dating or backdating.

COMPLETION, TIMELINESS, AND AUTHENTICATION OF MEDICAL RECORDS

- A. The hospital's Health Information Management Department is responsible for implementing and monitoring medical record management for inpatient and hospital-based outpatient services. Standalone CHLAMG physician practice sites will comply with the following:
 - a. Complete all medical records within 14 days from the date of discharge or date of service for outpatients.
 - b. Complete all operative reports and procedure notes immediately after surgery.
 - c. Include date, time, and/or signature for all medical record entries where hospital policy requires it.
 - d. Physicians who dictate reports to a transcription service must review the preliminary transcribed note, correct any errors or omissions, and sign the note to authenticate the accuracy and validity of the work.
 - e. Physicians who use voice activated documentation systems (e.g., Dragon®) must review the note, correct errors and omissions, and sign the note to authenticate its accuracy.
 - f. Complete and sign/authenticate all documentation used to support physician billing prior to submission of charges.
- B. PMG certified coders cannot use preliminary notes to assign ICD-9-CM, ICD-10-CM, CPT, and/or HCPCS codes to surgical cases, progress notes, ancillary reports, or other E/M services or procedures.
 - a. Coders with certification from the American Health Information Management Association (AHIMA) or the American Academy of Professional Coders (AAPC) must abide by their professional society's Standards of Ethical Coding, which prohibits the practice of coding from preliminary, unsigned, incomplete, and/or illegible documentation or risk loss of certification.
- C. CHLAMG may allow certain electronic methods of authenticating the medical record, including passwords, access codes, or key cards provided certain requirements are met. The methodology for authenticating the document electronically must comply with internal electronic signature standards (See Section X*** below: Authentication of Entries).
- D. Providers are responsible for safeguarding their electronic signature keys, passwords, stamps, etc.; any may not subrogate their responsibility for authentication to others.

ROUTINE REQUESTS FOR MEDICAL RECORDS FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (“TPO”)

- A. The hospital’s Health Information Management (HIM) Department staff will process routine requests for medical records for TPO. Requests for medical and billing records made at offsite CHLA-CHLAMG locations or standalone physician offices should have the requestor complete the *CHLAMG Release of Information Form (See *Appendix B)* and forward the completed form to:

CHLAMG / Attn: Compliance Director
3701 Wilshire Blvd, Suite 600
Los Angeles, CA 90010
Tel.: 323.361.2173 / Fax: 323.361.8490

OWNERSHIP, RESPONSIBILITY, AND SECURITY OF MEDICAL AND BILLING RECORDS

- A. All medical records of hospital-based physician practice sites are the property of that hospital. Medical records of standalone physician practice sites are the property of CHLAMG. All billing information and files related to CHLAMG patients are the property of CHLAMG. Physician practices must make information from medical records and associated billing files accessible to the patient, and thus available to the patients and/or the patient’s legal representative upon appropriate request and authorization.
- B. Responsibility for the medical record content for hospital inpatients and hospital-based out-patients lies with that hospital’s Director of Health Information Management. Responsibility for the medical records at stand-alone physician practices lies with the CHLAMG Compliance Director who is certified as a registered health information administrator or technician (RHIA or RHIT) pursuant to State of California requirements¹. These individuals are responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other healthcare professionals are responsible for the documentation in the medical record within required and appropriate time frames to support patient care and professional fee billing.
- C. Physician practices must maintain medical records and billing files in a safe and secure area. CHLAMG will ensure that there are safeguards in place to prevent loss, destruction, and tampering as appropriate.
- D. Exercise special care with medical records and billing files protected by the federal and State laws covering mental health records, alcohol and substance abuse records, teen health laws related to reproductive health² (See *Appendix C: California Minor Consent and Confidentiality Laws), reporting forms for suspected child abuse reporting, and HIV-antibody testing and AIDS research. (See *Appendix D: *Authorization for Use/Disclosure of PHI*)

CORRECTIONS AND AMENDMENTS TO RECORDS

- A. When an error is made in a medical record entry, do not obliterate the original entry. The inaccurate information should still be accessible.
- B. The correction must indicate the reason for the correction and the individual making the revision must include their signature and date.. Examples of reasons for incorrect entries may include “wrong date of service,” “wrong patient,” etc.
- C. Documents created in paper format:
- Do not place labels over entries for correction of information.
 - If personnel need to make a revision in a paper record, they should draw a single line through the incorrect entry and annotate the records with the date and the reason for the revision notes and signature of the person making the revision.
 - If CHLAMG originally created the document in a paper format, and then scanned it electronically, correct the electronic version by printing the documentation, correcting as above in (2), and rescan the document.
- D. Correct electronic documents by following instructions from the hospital’s Health Information Management department and/or Information Systems Department. The following scenarios provide documentation and amendment guidance:

¹ DHCS CCR Title 22, Division 5, §70747(b) - Medical Records Service;

² California Health & Safety Code §§ 123110(a), 123115(a)(1), Cal. Civ. Code §§56.10, 56.11

- a. Add an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.
 - b. The author may edit preliminary versions of transcribed documents prior to signing.
 - c. Once a transcribed document is final, it can only be correct in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include wrong date, location, duplicate documents, incomplete documents, or documents with error. The amended version must be reviewed and signed by the provider.
- E. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:
- a. Identify the new entry as a “late entry”
 - b. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed
 - c. Identify or refer to the date and circumstance for which the late entry or addendum is written.
 - d. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes
 - e. When late entries affect a professional service that has already been billed, the provider must notify the billing and/or compliance department so that a review of billing may be conducted.
- F. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. Examples of addenda include attending physician adding his/her personal documentation to resident notes, clinical findings determined after the original note was created and signed, etc.
- a. Document the date and time on which the addendum was made
 - b. Write/type “Addendum” and state the reason for creating the addendum referring back to the original entry
 - c. When writing an addendum, complete it as soon as possible after the original note
 - d. If the addenda affect the level of services previously billed by the attending physician (E/M or surgical service), the provider must notify the CHLAMG Compliance Department or PMG Coding/Billing Department.

G. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation and mechanisms may vary from one system to another

- a. In general, correcting an error in an electronic/computerized medical record should follow the same basis principles as corrections to the paper record.
 - b. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.
 - c. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.
- H. Copy and Paste Guidelines: The “copy and paste” functionality available for records maintained electronically eliminates duplication of effort and saves time, but must be used carefully to ensure accurate documentation and must be kept to a minimum.
- a. Copying from another clinician’s entry: If a clinician copies all or part of an entry made by another clinician’s source documentation, the clinician using the copied entry becomes responsible for the accuracy of the other clinician’s source document
 - b. Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical provider is responsible for ensuring the copied data is relevant and accurate
 - c. Copying for re-use of data: A clinician may copy and paste entries made in a patient’s record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.

AUTHENTICATION OF ENTRIES

- A. Electronic signature must meet standard for:
 - a. Data integrity to protect data from accidental or unauthorized change.
 - b. Authentication to validate the correctness of the information and confirm the identity of the signer
 - c. Non-repudiation to prevent the signer from denying that he or she signed the document.
 - d. At minimum, the electronic signature must include the full name and either the credential of the author or a unique identifier and the date and time signed.
- B. Electronic signature must be affixed only by that individual whose name is being affixed to the document, and no other individual
- C. Countersignatures or dual signature must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations
- D. Initial may be used to authenticate entire on flow sheets or medication records and the document must include a key to the identity of that individual
- E. Documents with multiple sections or completed by multiple individual should include a signature area on the document for all applicable staff to sign and date. Staffs who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.
- F. No individual shall share electronic signature keys with any other individual.