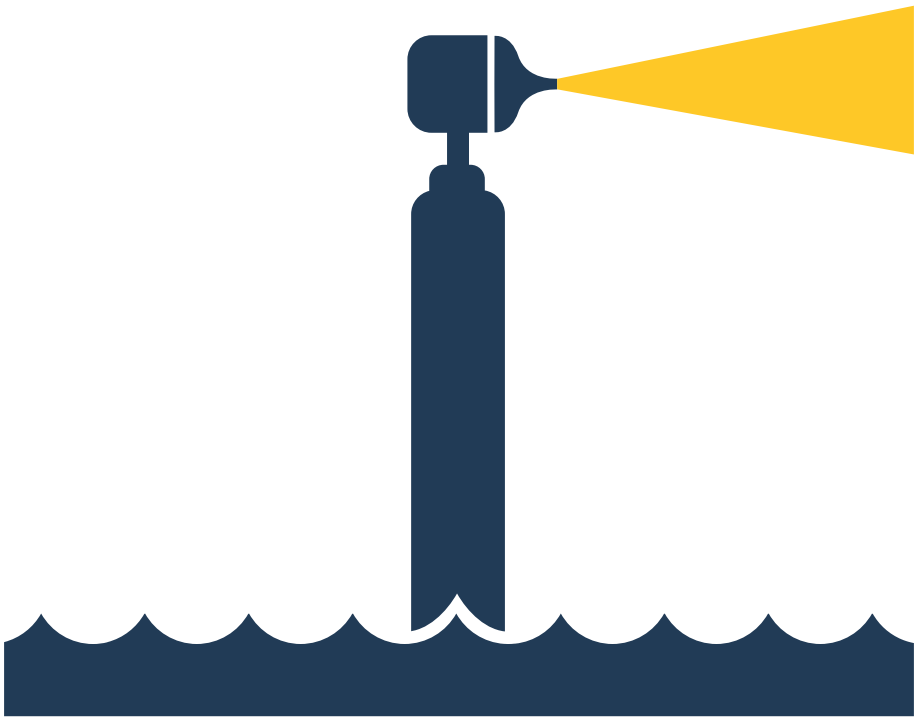
MEDICAL AND DENTAL RECORDS

A Patient Safety and Risk Management Guide for Members



Shining a light on risks and trends that others cannot see

The Doctors Company
TDC GROUP

EXPERT STRATEGIES AND GUIDANCE

Delivering the best imaginable service to our members is more than just a best practice for us. It is at the core of who we are. At The Doctors Company, our dedicated staff can provide expertise and support to help you mitigate risk, increase quality, and enhance safety in your practice environment.

This comprehensive guide provides key strategies for addressing medical and dental record documentation and administration. Our practical resource can help you safeguard and manage patient records, strengthen continuity of patient care, and protect you in the event of a malpractice claim or administrative or regulatory action.

Your patient safety risk manager can provide expert guidance and support whenever you have questions or need assistance.

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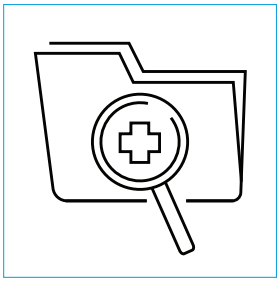
Consult with your personal or practice attorney and state licensing agency for requirements specific to your situation.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare practitioner considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

OVERVIEW

Establishing and managing patient records are critical healthcare functions. Advancements in technology, including EHRs, have expanded the concept of the healthcare record and its requirements. Federal and state regulations address virtually every facet of healthcare record content, security, storage, access, and disposal. Practitioners are well advised to keep current on the rules governing healthcare records—a potential challenge because the rules change frequently and vary by state.



CONTINUITY OF CARE

The most important reason for creating and keeping patient records is to provide information on a patient's care to other healthcare professionals. An accurate record of an individual's presenting complaints, physical examination findings, differential diagnoses, treatment plan, and the patient's response helps optimize patient well-being and promote more effective continuity of care.

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ADMINISTRATIVE FUNCTIONS

Beyond patient care, healthcare records serve other vital purposes. Accurate progress notes facilitate prompt payment and can help avoid unnecessary disputes over the level of care rendered and the amount of reimbursement owed to the practitioner. For example, billing audits—especially by CMS—require clear documentation demonstrating medical necessity, the nature and scope of the services rendered, and sufficient justification for the billing code utilized.

Patient records also establish the quality of care rendered in the event of a professional licensing board complaint, peer review inquiry, or civil rights investigation. Patient grievances may be filed based on an individual's faulty recollection of events, a failure to understand the course of treatment, or dissatisfaction that an adverse outcome occurred. When a patient record is well documented, allegations can often be resolved—frequently before a formal administrative process is even initiated. If the action moves forward, practitioners who have appropriate documentation are better able to support their decisions and treatment plans with greater confidence of achieving a favorable outcome.

PROFESSIONAL LIABILITY ACTIONS

A well-documented record increases support for the practitioner's defense in the event of a malpractice action. Judges and juries generally regard the patient record as the most trustworthy and probative piece of evidence because it is an independent document created during the normal course of providing care. The patient record establishes facts during a time when no pending conflict or other motivation was present that might shade or embellish the circumstances at issue.

The record and progress notes—key evidence in a professional liability action—are critical to helping refresh the practitioner's recollections of events that might have occurred years earlier. When introduced as independent documentary evidence, a well-documented record is a powerful defense to offset patient allegations that a practitioner was negligent in making decisions and providing treatment.

Without the patient's record, a healthcare professional might not be able to show that the treatment was appropriate and that it met the standard of care. Simply relying on the practitioner's testimony of general habit and practice to show that the standard of care was met—without supporting documentation to establish the treatment that was rendered—often fails to convince a jury that the treatment the patient received was consistent with professional standards.

A well-documented record increases support for the practitioner's defense in the event of a malpractice action.

For more information, see our article "Defensible Medical and Dental Records" at **thedoctors.com/records**.

DOCUMENTING PATIENT RECORDS

By thorough analyses of closed claims, The Doctors Company can readily identify claims in which documentation—whether accurate, faulty, delayed, or missing—contributed to patient harm and to the success or failure of defending a practitioner's care. Documentation issues, including insufficient or lack of documentation in areas such as clinical findings, clinical rationale, and informed consent, was the fifth-leading contributing factor in all claims and suits occurring between 2012 and 2023. Claims analysts identified documentation as a contributing factor in 21 percent of patient harm events. The following sections highlight our leading findings on documentation claims.

CLINICAL FINDINGS

Failure to adequately document clinical findings is the most common documentation risk factor. Clinical findings include pertinent positives and negatives in the history and physical portion of an exam, response to procedures and treatments, and patient factors such as adherence to the treatment plan, engagement, and comprehension. To document clinical findings:

- Use standard or facility-approved abbreviations.
- Use caution with templates. Make sure the template accurately reflects your examination. Remove sections that do not apply and add pertinent findings. Personalize the template to the patient.
- Record medication and allergy findings, particularly when the process identifies new or incorrect information.
- Provide notes on a patient's response to treatment.
- Note when the patient should return or other follow-up plans.
- Record all instances of patient noncompliance with the treatment regimen and your efforts to improve compliance.

DOCUMENTATION CONTRIBUTED TO

21%

of patient harm events in claims closed between 2012 and 2023

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CLINICAL RATIONALE

Documentation of clinical rationale should represent your diagnostic and clinical decision making, such as differential diagnosis, treatment plan, and medical necessity. To support your clinical rationale:

- Record all clinical decisions, such as reconciling signs and symptoms with diagnostic test results. Include your response to diagnostic study results and how the results were communicated to the patient.
- Include communication with other practitioners, what was learned, and how the information affects treatment or procedural decisions.
- Describe your rationale when not following the recommendations of consultants.
- Specify your clinical reasoning for rejecting or accepting clinical decision support (CDS) recommendations. If you use CDS—including computerized CDS (that is, machine learning algorithms) and artificial intelligence—affirm that the recommendations are appropriate and you agree with them. If you reject or accept them in part, document the clinical reasoning for your choice.

TIMELY DOCUMENTATION

Timeliness of entries in your patient record is critical. The more time that elapses between the patient encounter and note entry, the more likely it is that the record will be missing complete and accurate details. Treating similar patients within the same time frame can also affect a practitioner's ability to remember an individual's details.

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EHRs contain metadata showing exactly when information is entered in the record and who made the entry. Ensure that an addendum (information that was not available when the original entry was made) or amendment (to correct an erroneous entry) to the record is clearly noted with the date, time, and a brief explanation about why the entry is needed.

Include timely information about patient complaints or grievances and how they were handled. It may be desirable to include a direct quote of any comments.

Also see our article "The Faintest Ink: Documentation to Defend Quality Patient Care" at **thedoctors.com/faintest-ink**.

ALTERATIONS

Upon receiving notice that a malpractice suit is about to commence or has already been filed, practitioners must ensure the safety and integrity of the patient's record. Any changes made to the record after learning of a lawsuit raise questions about the practitioner's truthfulness, motives, and the quality of the care. Many practitioners and defense counsel have been embarrassed during discovery proceedings or at trial to learn that an earlier copy of the record differs materially from the record provided after litigation commenced.

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Forensic document experts are frequently called to testify that a paper record has been augmented or altered. In situations in which a practitioner has an EHR, counsel will retain information technology experts to conduct a metadata audit. The audit provides a complete analysis of every keystroke (including additions, deletions, and changes) and when the entries were made, by whom, and how long a document was open for review and revision. If experts discover that the record has been altered, it can also expose the practitioner to punitive damages and result in a licensing board investigation.

Avoid making self-serving comments, changes, or additions to the record after a potential claim has been brought forth.

EHR COPY/PASTE AND AUTOPOPULATE FUNCTIONS

Many EHR systems have a copy-and-paste feature. If you use this feature, review the text you copy carefully to ensure that it accurately describes your patient's current condition. In some cases, the defense of a lawsuit has been compromised by the use of the EHR copy-and-paste function because the entries had no personalization and were all nearly identical. Another pitfall is copying and pasting a portion of documentation that is no longer relevant to the patient. It can give the impression that the practitioner is lazy or careless.

Exercise caution when using EHR templates and be sure to understand the system's functionality. The EHR template may be designed to autopopulate a "normal exam" for the body part chosen. As a result, the documentation may not reflect abnormal findings in the physical exam or may reflect a normal exam for an area that could not be physically examined in a telehealth visit. If the treatment plan and patient instructions are not part of a template, include the information as free text.

In some cases, the defense of a lawsuit has been compromised by the use of the EHR copy-and-paste function.

During a deposition, the plaintiff's attorney may ask these questions about incorrect information in the EHR's autopopulated fields:

- *"Is the information in this record accurate or not?"*
- *"Do you bother looking at your records?"*
- *"If these 'autopopulated' fields are incorrect, can we trust anything in this record?"*
- *"Do you deliver the same level of care as you do in recordkeeping?"*

Contemporaneous and accurate patient record documentation is vitally important in the defense of a malpractice claim. Familiarize yourself with the EHR templates and review any autopopulated fields for accuracy.

MEDICATION DOCUMENTATION

Medication documentation should include a current list of all medications the patient is taking—including prescription, herbal, recreational, and over the counter. During each visit, confirm the medication list and update it as appropriate. When new medications are prescribed, the next visit should include a comment on the effect of the medication and how it was tolerated by the patient.

E-prescribing can result in serious errors if the prescription is not carefully reviewed before being sent. While you may have a staff member enter the information, you assume all responsibility for accuracy once you sign the prescription. A well-designed EHR will list medication choices on the drop-down menu according to the strength of the drug in ascending order (lowest dose as first choice). This prevents selecting the strongest dosage in error. If your system lists medication doses in descending order (strongest dose at the top of the drop-down menu), consider making a system adjustment.

A well-designed EHR will list medication choices on the drop-down menu according to the strength of the drug in ascending order (lowest dose as first choice).

DOCUMENTATION BY OTHERS

Failure to document clinical findings is another common contributing factor in malpractice claims and can be more problematic when others assist with documentation. The following tips address this risk:

- If you have other clinical staff enter some of the history and physical information, be certain the identity of that person does not disappear when you are entering your portion. The system should clearly identify every person who makes an entry into the record.

- Hire staff with the required skill set and carefully review their work. Ultimately, you are responsible for the content of the documentation.
- If you use in-room, remote, or digital scribes for assisting in documentation, describe your clinical findings out loud—what you are seeing, hearing, smelling, and palpating—during the physical examination.
- Document the name of the scribe and that you were present during the scribing.
- Review scribed documentation before closing the note. Your authentication (that is, your signature or electronic signature with the date and time) indicates agreement that the scribed content is complete and accurate.
- Use the same authentication process with note development that is augmented by artificial intelligence.
- If review of scribed documentation does not occur until after the note is closed, clarify any incorrect or missing information using an addendum or late entry and authenticate your clarification.

EDUCATIONAL MATERIALS

If you give educational materials to patients, document the record with the materials the patient received (and keep a copy of office educational materials in an administrative file for later reference). Additionally, if you provide printed discharge instructions, include them in the record. This information is especially important for continuity of care within your practice and for any subsequent treating practitioner.

TELEPHONE COMMUNICATION DOCUMENTATION

Effective telephone communication and its documentation are vitally important in preventing and defending litigation. Disagreements about what was said during telephone conversations can be a major issue in malpractice cases. Consider these documentation processes to mitigate risk:

- Document all patient telephone conversations in the patient record—including those received and returned after hours. Include the date and time of each contact and when follow-up is completed.
- Record immediately all details about the information you received, what you advised, and the orders you gave. This action is especially important when a telephone call occurs after office hours or on a weekend.
- Implement an office process for calls received during office hours. Office staff should tell the caller when the practitioner is most likely to return the call. Include tracking and follow up to ensure that the caller's questions and problems are resolved and documented.
- Document a patient's hospital medical record with telephone conversations about the hospitalized patient—including any conversations with nurses or other practitioners.

For additional strategies, see our article "Telephone Communication for Healthcare Providers: Safety Strategies" at **thedoctors.com/telephonecommunication**.

TEXT AND REMOTE TECHNOLOGY DOCUMENTATION

Healthcare practitioners have embraced smartphone and smartwatch technologies to communicate by text messages and access health information. Sending text messages through secure messaging systems is instantaneous, convenient, and direct. It reduces the time waiting for colleagues to call back, and it can expedite patient care by facilitating the exchange of critical lab results and other necessary patient data.

Smart technology is not just for peer-to-peer use: Empowered patients are requesting more access to care providers and patient records to manage their healthcare needs. Patients are also investing in mobile health technologies that provide continuous vital sign monitoring and generate health data that can be sent to their practitioners.

> Many EHR products now interface with secure messaging systems or the secure systems are integrated into the EHR product.

Safeguarding Against HIPAA Violations

- Before communicating with patients through electronic technologies, a practice must have in place a secure HIPAA-compliant messaging platform that interfaces with the EHR and strong administrative procedures. HIPAA compliance is paramount to the practitioner's ability to communicate safely and send appointment reminders, alerts, and other follow-up notices.
- Text messages among colleagues should also be encrypted and exchanged in a closed, secure network designed specifically to safeguard protected health information (PHI), not on personal messaging systems. A secure messaging platform allows for the encrypted flow of information and storage in the patient record. Many EHR products now interface with secure messaging systems or the secure systems are integrated into the EHR product.
- Implementing a secure messaging platform must include establishing electronic communication policies regarding the proper and improper uses of texting—which means specifying what types of information may or may not be texted. Patients must also be educated on how the practice uses electronic communications and/or texting and be given the options to consent or opt out of those communications.

Ensuring Accuracy

- Shorthand and abbreviations are commonly used in text messaging. The informal nature of text messages can increase the chances of miscommunication. It is important to ensure accuracy and use standardized and approved abbreviations, particularly when patient information is exchanged over text.
- Texting cannot substitute for a dialogue with a colleague concerning a patient. If the matter is critical or you have any doubt about the communication, it is best to speak directly with your colleague.

Discoverability

- Just as phone records are discoverable during litigation, so are text messages on personal and work-designated smart devices. When changes occur in the patient's condition or a serious event takes place, limit texting to messages over a secure messaging platform, and ensure that message content is appropriate for the patient record. Do not use personal messaging systems that are not compliant with the HIPAA Security Rule or for messages containing PHI. For example, if you don't have access to a secure messaging system and need to use your personal device, text a generic message such as "please call urgently."

> Avoid expressing your opinion in a text about the care others have provided, unexpected events, or possible errors.

- Communication about patient care should be made in person or by person-to-person phone call and documented in the patient record. If texting is the only way to communicate, keep messages brief, professional, and to the point. If you would not document the communication in the patient record, do not say it in a text message. Avoid expressing your opinion in a text about the care others have provided, unexpected events, or possible errors. Instead, communicate your understanding of events using an appropriate format, such as in an incident report or during a postevent investigation.
- Text messages from medical device representatives and other vendors who are present during patient care are also discoverable. Text messages should not contain discussions, opinions, or comments that would not be included in the patient record.

For additional information, see our article "Smartphones, Texts, and HIPAA: Strategies to Protect Patient Privacy" at **thedoctors.com/texting**.

TIPS FOR TELEHEALTH CLINICAL DOCUMENTATION

Telehealth clinical documentation plays a significant role in demonstrating regulatory compliance, establishing medical or dental necessity for billing, and defending the practitioner in the event of a licensing board complaint or professional liability claim. Due to the unique differences between an in-person patient visit and telehealth, documentation plays an essential role in proving that the standard of care has been met. The practice of telehealth creates additional and specific documentation requirements.

Consider the following nine tips for documenting telehealth care:

1. **Modality:** Specify clearly in the patient's record the telehealth modality used. Examples include "secure interactive audio-video session using [name of] telehealth platform," "telephone medication management consultation," or "asynchronous diagnostic test follow-up by portal/text/email."

2. **Geography:** Note the patient's physical location and geography. For example, including "at her home in Tennessee" is necessary for billing purposes and determining venue in the event of regulatory or professional liability action. Also document the practitioner's location as "in the clinic," "from the hospital," or "from the home office."

3. **Informed consent:** Obtain informed consent for telehealth visits. Advise patients about the risks of a telehealth visit, including the potential for technical difficulties, information security concerns, and that it may be necessary to convert the visit to an in-office visit depending on patient needs. In the progress note, summarize the discussion, the questions asked and answered, and the patient's decision. Include a copy of the signed consent form. Find our sample "Telehealth Informed Consent" form on our Informed Consent Sample Forms page at **thedoctors.com/sampleconsentforms**.

4. **Identity:** Confirm patient identity to reduce the risk of billing fraud and identity theft. Ask new patients to hold a photo ID close to the camera. Document confirmation of patient identity. Patients also have the right to ask for practitioner identification.

5. **Appropriateness:** Determine quickly if the patient and environmental conditions are appropriate for a telehealth visit. Some patients may not be appropriate candidates for telehealth visits based on their cognitive status. If the patient cannot answer questions or provide an accurate history and no support person is available, the visit may need to be rescheduled. Documentation in this situation might include "the visit was rescheduled at the patient's request because her husband could not be available." Evaluate and address distractions in the environment. Document patient assessment, environmental conditions, actions taken, and recommendations made. For more information on addressing patient distractions, see our article "Manage Patient Distraction During Telehealth Visits" at **thedoctors.com/distractedpatients**.

Due to the unique differences between an in-person patient visit and telehealth, documentation plays an essential role in proving that the standard of care has been met.

6. **Others present:** Include documentation of all participants. Others may be present at the patient's location and may assist with or affect the quality of the visit. Document in the progress note the name and relationship of all individuals present on the patient's side of the interaction. For example, document "visit conducted with child sitting on mother's lap." On the practitioner's side, document the names of assistants who are present and their purpose. For example, a medical assistant may serve as a chaperone during remote sensitive visual examinations. In addition, document the use of interpreters who assist from a third location by video or telephone.

7. **Assisted assessment:** Plan for and provide instructions to patients if they will be performing tasks during the examination. With preparation, patients may be able to measure and report their weight, vital signs, and home point-of-care testing results. Document results and specify "patient provided." When patients

assist in various aspects of physical examination, document the details as "patient assisted." For more information on patient-assisted assessment, see our article "Strategies for Effective Patient-Assisted Telehealth Assessments" at **thedoctors.com/patientassisted**.

8. **Safety concerns:** Scan the patient's environment for possible safety concerns. As the volume of telehealth visits increased during the pandemic, clinicians were afforded a window into patients' homes and lives that would not otherwise have been possible. This opportunity was both a blessing and a challenge. Visualizing the patient's surroundings facilitates patient safety activities such as fall reduction, environmental allergy assessment, and brown bag medication checks. In some cases, however, practitioners may see conditions that require intervention that are not directly related to the visit. Examples include evidence of hoarding, unsanitary conditions, abuse, and potential human trafficking. Objectively document observations, discussions with the patient, recommendations, and follow-up plans.
9. **Quality improvement:** Consider revising EHR templates to include some of these documentation recommendations as checkboxes, drop-down menus, or text macros. Periodically evaluate telehealth visit documentation to ensure compliance with the recommendations.

Following these nine tips can help you ensure that your telehealth documentation is patient-centered, comprehensive, and effective. You can also benefit from familiarizing yourself with the regulatory and payer requirements specific to your practice location(s).

For additional guidance, consult our Telehealth resources at **thedoctors.com/telehealth**.

INFORMED CONSENT AND REFUSAL DOCUMENTATION

Documentation is a key component of the informed consent process that cannot be entirely delegated to another member of the healthcare team. If the practitioner-patient discussion proceeds successfully and the patient requests treatment, the practitioner is required in some jurisdictions to write a note in the patient's record.

To some extent, healthcare practitioners who use an informed consent document can protect themselves further by including a statement to the effect that the form covers information that applies only generally and that the practitioner has personally discussed specific factors with the patient. The consent document must include the patient's name, healthcare practitioner's name, diagnosis, proposed treatment plan, alternatives, potential risks, complications, and benefits. Additionally, the consent document must be signed and dated by the patient (or the patient's legal guardian or representative). Many consent forms also require a healthcare practitioner's signature.

Consent forms should include statements to be signed by the patient and the healthcare practitioner. The patient attests to understanding the information in the treatment agreement. The practitioner attests to answering all questions fully and to the belief that the patient/legal representative fully understands the information. These statements help defend against any claim that the patient did not understand the information.

Some states have specific requirements for informed consent forms, procedure-specific disclosures, and legal standards for disclosure of risks. Check your state for requirements. For example, Texas maintains lists of procedures and attendant risks and hazards through the Texas Medical Disclosure Panel. Learn more at **hhs.texas.gov/providers/health-care-facilities-regulation/texas-medical-disclosure-panel**.

Consider incorporating the following strategies into your informed consent process:

- Document informed consent discussions, including the patient's specific questions and whether anyone else was present during the discussion.

> Documentation is a key component of the informed consent process that cannot be entirely delegated to another member of the healthcare team.

- Obtain written informed consent from the patient using a consent form as required by policy and state law.
- Develop and use procedure-specific forms that the patient can sign when the informed consent discussion takes place. Place the signed consent form in the record.
- Ensure that the consent form risk section is comprehensive—including the risks of pain, bleeding, potential need for additional procedure(s), and dissatisfaction with cosmetic outcome, if applicable.
- Obtaining consent from the patient after a sedative or sleep-inducing medication is administered is not recommended. However, when a change in the patient's condition requires a change in treatment, secure the patient's consent. Document the patient record thoroughly with the facts and conditions surrounding the need for the revised consent.
- Ensure that any additions or corrections to the consent form are dated, timed, and signed by both parties.
- Obtain witness verification of the patient's signature. Any member of the healthcare team may sign as a witness to the patient's signature, although this serves only to verify that it was the patient who signed the form. The witness does not obtain consent or verify the patient's competency to give consent.
- Address a patient's questions or obvious lack of understanding about the procedure as soon as possible. These responsibilities cannot be delegated.
- Use an interpreter when necessary for the informed consent discussion and document the name/agency of the interpreter used.
- Translate consent forms to the most common non-English languages that you encounter in your practice, and verify that the form is translated correctly.

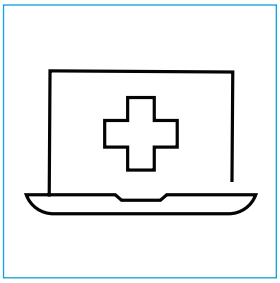
- Evaluate patient comprehension using teach-back. Ask patients to explain their understanding of the consent discussion in their own words. Correct any misunderstandings and continue the process until the patient is accurately able to explain the planned procedure, risks, and benefits. Document in a progress note a summary of the discussion, including questions asked and answered and the patient's ability to teach-back. This will increase the likelihood that you will be able to manage the patient's expectations effectively.

Visit our Informed Consent/Shared Decision Making page at **thedoctors.com/informedconsent** to find additional resources such as sample forms and articles like "Informed Consent: Substance and Signature" and "Obtaining Informed Consent in Teaching Institutions."

If you and your patient have completed the informed consent process and your patient refuses a recommended treatment or therapy, include documentation of the refusal in the record and outline your discussion of the risks and consequences of the refusal. Documenting an informed refusal is as important as documenting informed consent.

Find our article "Informed Refusal" at **thedoctors.com/informedrefusal** and our sample form "Refusal to Consent to Treatment, Medication, or Testing" at **thedoctors.com/sampleconsentforms**.

OPEN NOTES DOCUMENTATION



On April 5, 2021, the 21st Century Cures Act prohibition on information blocking (also known as the open notes requirement) went into effect. The Cures Act Final Rule requires that patients must be able to access information in their EHRs "without delay" and provides transparency by allowing patients convenient access to their electronic health information.

While emphasis has been placed on giving patients immediate access to the practitioner's notes, the 21st Century Cures Act also includes a requirement for immediate patient access to test results. Many states, however, have laws requiring that certain test results, such as a diagnosis of a malignancy, be conveyed by a licensed practitioner. If either an exception or a state law exists, the practitioner would not be considered to be information blocking by delaying the release of certain test results to the patient.

For more information, see our article "Documentation Strategies for Open Notes in Healthcare: The Cures Act" at **thedoctors.com/opennotes**.

The Cures Act Final Rule requires that patients must be able to access information in their EHRs "without delay" and provides transparency by allowing patients convenient access to their electronic health information.

Consider the following strategies to help ensure that your notes will be well received by patients:

- Document with the knowledge that your patients can and may access their records.
- Invite patients to participate in the note-writing process. During visits, ask patients to read the notes you take to confirm understanding and accuracy. Encourage your patients to access the system later to review the notes.
- Consider formatting your EHR to display your note with the assessment and plan sections as the first items. Your EHR system may allow changes based on your needs; e.g., you document in a typical subjective, objective, assessment, and plan (SOAP) format, but once the note is final, the assessment and plan are displayed front and center.
- Consider composing at least a portion of the note as instructions addressed directly to the patient. Using direct language may help reinforce instructions for patients.
- Emphasize important instructions and information with formatting. If your system allows you to change how text looks, add bolding to important statements or increase the font to a bigger point size.
- Avoid using medical terminology and acronyms or abbreviations. Patients do not expect a layperson's terminology, but they need to be able to understand the note.
- Make technology work for you. It may be possible to configure your EHR to spell out acronyms and abbreviations automatically. Offer patients a list of common medical or dental abbreviations or provide links to sites that provide an accurate glossary of clinical terms. You may also be able to create templated versions of common explanations that you frequently provide to patients.
- Avoid subjective comments about the patient's appearance or manner. Instead, use respectful person-first language that maintains the patient's dignity by seeing the patient as a person first and not labeling an individual with a disease or condition. For example, *the patient is affected by obesity* instead of *the patient is obese*.
- Train practice staff to keep any subjective comments out of written communication, task notes, and documentation. Task notes include items like reminders from staff members to practitioners to return a call from the patient and comments exchanged between staff and practitioners.

THE CURES ACT: ADDITIONAL RESOURCES

Final Rule
healthit.gov/topic/oncs-cures-act-final-rule#

Understanding Electronic Health Information Guide
healthit.gov/sites/default/files/page2/2021-12/Understanding_EHI.pdf

Information Blocking
healthit.gov/topic/information-blocking

Information Blocking Exceptions
healthit.gov/sites/default/files/page2/2020-03/InformationBlockingExceptions.pdf

Frequently Asked Questions
healthit.gov/faqs

United States Core Data for Interoperability
healthit.gov/isa/united-states-core-data-interoperability-uscdi

RESPONDING TO REQUESTS TO AMEND PATIENT RECORDS

Under the HIPAA Privacy Rule, patients have the right to *request* amendments to their healthcare records. Practitioners have the right, however, to *determine* if the changes will be made. In these situations, document the record with both the patient's request and the practitioner's response. Consider the following scenarios and points outlined below:

Scenario 1: During an executive physical examination, a practitioner asks the patient how many alcoholic drinks he has in a day. Because the patient does not drink every day, he responds that he has about five drinks each week. The practitioner incorrectly documents "ETOH: 5/day." Subsequent healthcare practitioners who have received copies of the physical examination refer to the patient's "daily" alcohol intake. The patient eventually identifies the source of the confusion and requests an amendment to the medical record.

Scenario 2: A patient returning for follow-up of back strain due to gardening now insists that the original injury occurred at work and wants the prior visit note changed.

DOCUMENTING PATIENT REQUESTS

When you receive a patient request for any kind of amendment to a healthcare record, these strategies can help ensure clear documentation:

- The patient's request must be in writing and must be signed and dated.
- Notify the patient that the request will become part of the permanent record.
- The request must be directed to the practitioner who originated the portion of the record the patient wants to amend.
- The request must state which portion of the record the patient wants to amend and specify how and why it should be amended.
- The patient's request is then filed in the record with the pertinent entry.
- The patient's request for change and the practitioner's written response become part of the permanent record.

PRACTITIONER RESPONSE

Practitioners have the right to determine whether a requested amendment will be made. Take the following steps if you agree (or partially agree) with a patient's request:

- Prepare and send a *written* response to the patient within *60 days* of receipt of the original request. Sign and date the response.

- Indicate on the patient's record that "per the patient's request, the record is amended as follows," and make any appropriate changes.
- Place a copy of the patient's request and the written response with the pertinent entry in the patient's record.
- Make a reasonable and timely effort to inform other individuals who received the original record and provide them with the amendment. This is especially important if relying on the original information could be detrimental to the patient.

Follow these steps if you disagree with the patient's request:

- Prepare and send a *written* response to the patient within *60 days* of receipt of the original request. Sign and date the response.
- Use plain language (rather than technical terms) so that the patient will understand.
- Place the response with the request in the patient's permanent record, and include the following information:
  - The reason for the denial. Common reasons to deny a patient's request include that the practitioner who received the request did not create the record entry or that the patient record is accurate as is.
  - A statement advising that the patient may submit a written reply disagreeing with the denial.
  - A statement telling the patient how to submit a reply to the practitioner or clinic.
  - A statement outlining that, regardless of whether the patient wishes to reply to the denial, copies of the original request and the practitioner's denial will become part of the patient record and be included in responses to future inquiries regarding the patient's healthcare information.
  - Notice to the patient regarding how to make a complaint to the healthcare practitioner or a HIPAA complaint to the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights, either online at **ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf** or by telephone at 800.368.1019.

Providing patients with a preprinted amendment request form can facilitate the process. The form should include the required information relative to the patient's request and fields to sign and date the request.

Resources

Requests to Amend a Medical or Dental Record, thedoctors.com/amendingrecords

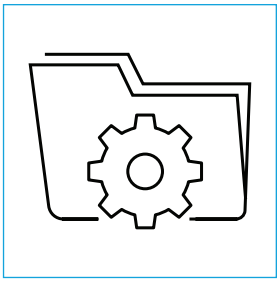
45 CFR § 164.526, Amendment of protected health information, ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.526

U.S. Department of Health and Human Services, Summary of the HIPAA Privacy Rule, hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

RETAINING PATIENT RECORDS

Healthcare practitioners must be aware of the different record retention requirements imposed by state and federal laws, agencies, licensing boards, and contracted health plans, in addition to any recommendations from professional associations.

FEDERAL AND STATE LAWS



Federal laws impose mandatory record retention requirements on healthcare facilities and practices. For example, the Medicare Conditions of Participation require providers and suppliers to maintain records for seven years from the date of service (42 CFR § 424.516[f]) and Medicare managed care program providers to retain records for 10 years (42 CFR § 422.504[d]), whereas OSHA requires an employer to retain records for 30 years for employees who have been exposed to toxic substances and harmful agents (29 CFR § 1910.1020[d][1]). Additionally, HIPAA privacy regulations require that documents created in compliance with the Privacy Rule (such as policies, procedures, and accountings of disclosures) be retained for six years from when the document was created or the last effective date, whichever is later (45 CFR § 164.530[j][2]). (Find the Code of Federal Regulations at **ecfr.gov**.)

The healthcare professions have primarily been regulated by the states rather than by a federal oversight agency. As a result, record retention laws and regulations differ from state to state, so it is important to check and follow state requirements.

Record retention policies should not be based solely on the state statute of limitations. This is because case law in various jurisdictions may extend the allowable time for the patient to bring a malpractice action. An example of this situation is when a patient could not discover that the injuries were caused by wrongdoing within the statutory timeframe.

Record retention laws and regulations differ from state to state, so it is important to check and follow state requirements.

CONTRACTS

Contracted healthcare plans can also affect the length of time records must be retained. For example, Medicare managed care plans require practitioners to maintain records for 10 years. Check any signed managed care agreements or contracted healthcare plans to ensure compliance with the record retention requirements of those agreements.

BOARD AND ASSOCIATION POLICIES AND RECOMMENDATIONS

When state or federal laws and contracts are silent on record retention, your attorney, state licensing board, or professional association may be able to provide policies or recommendations on how long a practitioner should keep records.

For example, the Colorado Medical Board Policy 40-07 recommends retaining medical records for a minimum of seven years after the last date of treatment for an adult and for seven years after a minor has reached the age of majority, or age 25. In California, where no overall statutory requirement exists, the California Medical Association concluded that, while a retention period of at least 10 years may be sufficient, all medical records should be retained indefinitely or, in the alternative, for 25 years.[1]

THE DOCTORS COMPANY RECOMMENDATIONS

Once a record has been destroyed, it is difficult—if not impossible—to defend a case. We encourage healthcare professionals to consult with their legal counsel regarding how the law in the jurisdictions relevant to their practice has been interpreted by the judicial system.

You must follow your state's specific guidelines or laws. Where no statutory requirement exists, The Doctors Company recommends the following for retaining patient records:

ADULT PATIENTS

10 years from the date patient was last seen

MINOR PATIENTS

28 years from date of birth

DECEASED PATIENTS

5 years from date of death

Patient records, whether paper or electronic, must be maintained in a HIPAA-compliant format. If using a commercial service, the records should be stored with a reputable document storage company. Many companies offer alternative methods for paper document management, such as electronic scanning and storage, and may offer storage of previous electronic records when software formats change. Storing closed or archived records at a residence or on a home computer puts records at risk of damage from fire, flood (or other weather-related disasters), vermin, loss due to theft, or unauthorized access.

If a practitioner chooses to destroy clinical records after the required retention period, confidentiality must not be compromised. Use a record destruction service that guarantees a method of destroying records that does not allow further access to the information. Records that are destroyed should be listed on a log with the date of destruction.

WHAT RECORDS SHOULD YOU RETAIN?

Retain all records that reflect the clinical care provided to a patient, including practitioner notes, clinical staff notes, diagnostic testing, medication lists, photos, videos, x-ray films, ECG recordings, fetal monitoring strips, and/or dental models/casts. Additionally, records from other practitioners that directly relate to your care and are maintained as a regular part of your record should be kept for the same period that you retain your own records. This is especially true if you have relied on any of the previous records or information when making clinical decisions.

Review patient bills for any reference to care provided. For example, review a bill to determine if it shows a limited examination or a complete examination with diagnostic tests obtained or requested. If the billing document shows that care was provided, it may be in your best interest to keep the bill for as long as you retain the record. Otherwise, retain the bill for the same length of time as other business records and in accordance with federal and state income tax requirements.

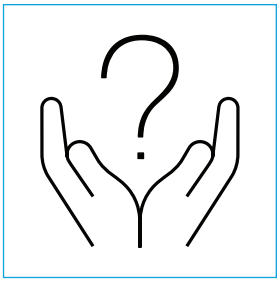
Storing patient records for the recommended time can generate a financial expense for the practitioner or practice. Given the importance of records in ensuring continuity of care and defending malpractice actions, however, it is vital to make sure that records remain available.

Also see our article, "Medical and Dental Record Retention" at **thedoctors.com/recordretention**.

Reference

1. Retention of Medical Records, Document #4005, California Medical Association, CMA On-Call, cmadocs.org/health-law-library

RESPONDING TO REQUESTS TO RELEASE PATIENT RECORDS



Healthcare practices respond to many types of clinical documentation requests from different sources. Federal and state privacy laws specify the types of record release that are mandatory or permitted and how the inquiries should be addressed. Practices that submit electronic claims for payment, eligibility requests, claim status inquiries, and requests for authorization are governed by federal HIPAA privacy, security, and breach notification rules. It is also necessary to comply with the rules concerning healthcare records in the jurisdiction in which you practice, including the requirements for minimum content, retention, storage, and release.

The steps outlined here can help healthcare professionals respond to record requests.

1. **Require a Written Request.** Releasing PHI requires a written request and, except for specific exemptions, the request must be accompanied by a valid HIPAA-compliant authorization signed by the patient or a court order.

   - If you receive an oral request for patient records, either in person or by telephone (including from a law enforcement representative), respectfully and politely tell the individual that all requests for clinical health documentation must be submitted in writing (and, if appropriate, on official letterhead), signed, and dated. Advise the individual that, once you receive the written request, it will be reviewed as soon as possible and a prompt response will be provided.

2. **Do Not Refuse to Provide Records.** Do not unilaterally refuse to provide records to a properly authorized individual who presents an appropriate written request.

   - It is not appropriate to withhold requested records or portions of a record because a patient has an outstanding balance for services rendered, disputes the treatment provided, or disagrees with fees that have been charged. With very few exceptions, patients are entitled to a complete record set maintained by the practice pursuant to applicable statutes, regulations, and administrative code provisions.

   - Seek advice from your professional liability carrier, risk manager, or corporate counsel. Withholding records can antagonize the patient and irreparably injure the patient-practitioner relationship. It may also provoke a complaint to your state licensing board, state department of consumer affairs, or the federal Office for Civil Rights, or result in negative posts on social media that could have an adverse impact on your professional reputation.

Knowing how to respond to a subpoena or a request for records that contains PHI can be complicated.

3. **Identify the Type of Request.** Knowing how to respond to a subpoena or a request for records that contains PHI can be complicated. Failing to comply can result in serious financial and legal penalties.

   - If you receive a request for records related to professional liability (for example, if you or another treating clinician has been named in a lawsuit or administrative complaint, or you believe a claim, lawsuit, or administrative complaint may be filed), contact The Doctors Company promptly. We can review the inquiry to ensure its validity and assist you in identifying the nature, scope, and timing of the documentation you must produce. This recommendation applies to the following types of requests:

     – Subpoena.

     – Signed authorization presented by a third party.

     – Court order.

     – Written inquiry by a government oversight agency (such as a state licensing board or the Office for Civil Rights).

     – Billing or reimbursement question by a private payer or CMS.

     – Official query by law enforcement or a coroner's office.

   - If you receive a request for records related to a workers' compensation claim, contact your workers' compensation insurance carrier for additional guidance.

4. **Identify the Origin of the Request.** Determine who issued the subpoena and its validity.

   - Was it issued by an in-state court order or signed by a judge, or is it a grand jury subpoena? If yes, the record generally must be released.
   - Although not required when the request derives from a court order, it is recommended that the practice contact the patient to ascertain agreement with the inquiry. Documenting the patient's response in the clinical record is an important step in safeguarding privacy rights and helping to protect the practitioner from a complaint by a government oversight agency.
   - If the subpoena was signed by a court clerk or an attorney, it is not a court order but may be valid under applicable federal and state regulations. Releasing information may require additional steps to comply with HIPAA and the state privacy laws in force in the jurisdiction where you practice. All requests based only on an attorney-generated correspondence should be accompanied by the patient's written authorization to release.

5. **Identify the Scope of the Request.** Establish the extent of the requested information. Does the request cover a specific date of service or the entire record? Does the information include PHI that is covered by HIPAA and state privacy laws?

   - If the request is for a specific time period or service, send only the records for the dates or service requested.

- Additional conditions apply if the request includes highly sensitive, specifically protected information (for example, records about treatment of minors; behavioral, psychiatric, or mental health; drug or alcohol treatment; HIV, AIDS, and STD testing or treatment; or substance abuse programs). These types of requests generally require written patient authorization or a court order covering the specifically protected information.

Ordinarily, you are not expected to provide the material on short notice, but you are required to respond in a timely manner.

6. **Be Aware of Deadlines.** Respond swiftly to record requests.

   - Ordinarily, you are not expected to provide the material on short notice, but you are required to respond in a timely manner, as defined under applicable state law and in the HIPAA Privacy Rules. Jurisdictions vary as to when requested information must be produced. The timeline depends on the nature and purpose of the request and the identity of the individual seeking the clinical material. Failure to respond or object may lead to charges of contempt of court.

   - Sometimes records are requested with very short deadlines that do not allow the practitioner enough time to contact the patient for permission or notification, if required. Contact us for guidance. Depending upon the complexity of the request and the volume of records being sought, additional time to respond may be needed. In that event, notify the requesting party about progress in fulfilling the response and any additional time needed to complete it. The nature of the interaction with the individual or entity seeking the material should be timely and succinctly notated in the patient's notes.

7. **Additional Considerations**

   - **Determine Fees for Record Release.** Federal HIPAA privacy rules permit covered entities to charge an individual who has requested a copy of the individual's PHI (even if the individual is directing the copy be sent to a third party) a reasonable, cost-based fee for the copy that covers *only* certain labor, supply, and postage costs that may apply in fulfilling the request. See 45 CFR 164.524(c)(4) and HIPAA FAQs for guidance on calculating an actual cost, average cost, or flat fee for electronic copies. Consult your corporate counsel for guidance on state laws and regulations relating to charges for patient record copies or access.

   - **Office Tracking of Record Release.** An important safeguard in the office is implementing a procedure that requires the personal approval of the patient's treating practitioner or the office manager before information from the patient's record can be copied or released. If this is not feasible for all requests, flag records in the EHR that do require approval, such as those containing information on patient abuse or psychiatric treatment.

The process for tracking patient records should also include documenting when and where the copied record was sent. In the event of litigation, it is helpful for your legal representative to be able to reconstruct when the record was previously copied and who received it.

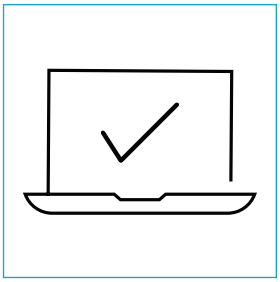
Periodically audit office policies for compliance with record release and tracking.

- **Deceased Patients' Record Release.** Federal HIPAA rules permit release of a deceased patient's record to a personal representative (the executor or administrator of the deceased's estate) or persons authorized by state law or court order to act on behalf of the deceased individual. Consult with local counsel for state-specific requirements.
- **Communications With Your Insurer or Attorney.** Any communications with your insurance carrier or attorney should be kept separate from the patient's health record, thereby eliminating the possibility that they will be inadvertently copied or provided to opposing counsel without a court order specifically compelling their production.

Find sample forms, including "Authorization for Use or Disclosure of Health Information," at **thedoctors.com/sampleconsentforms**.

COMPLYING WITH PATIENT RECORD REQUIREMENTS WHEN CLOSING OR RELOCATING A HEALTHCARE PRACTICE

If you are transitioning your practice, the information in this section can help you anticipate and address patient record requirements.



- Make provisions for completing all patient records, especially inpatient hospital records.
- Notify patients that they may designate a new practitioner who can receive a copy of the records. *Never give original records to the patient*.
- Provide patients with easy access to their records by enclosing a HIPAA-compliant authorization form in the notification letter you send to them.

Find a sample authorization form at **thedoctors.com/sampleconsentforms**.

Texas members: You can download the state-approved form provided by the Attorney General of Texas at **texasattorneygeneral.gov/consumer-protection/health-care/patient-privacy**.

- Provide a copy of the record to the patient's new practitioner or to the patient as directed when the patient returns the signed authorization. You may apply charges as permitted by state law.
- Provide patients with information on where their records will be stored in the future and the length of time (in years) that the records will be retained. Include a permanent mailing address or post office box number for future record requests.
- Arrange a secure storage place consistent with federal and state privacy laws for the original patient records that is safe from unauthorized access, theft, vermin, fire, flood, or other weather-related disasters.

Whether you are closing a practice or relocating, you must comply with state and federal laws that govern patient record retention (both paper and electronic formats). The possibility of a lawsuit after a practitioner has left or a practice has closed always exists. To help defend against any future claims, HIPAA-compliant record retention is paramount.

TRANSFERRING RECORDS TO A CUSTODIAN

Original patient records may be transferred to a custodian for storage. Custodians who agree to retain records can be replacement practitioners, nonclinical custodians, or commercial storage facilities. Commercial custodial arrangements for retaining records are usually entered into for a fee. All agreements should be in writing. A written custodial agreement should guarantee future access to the records for both the practitioner and patients and include the following provisions:

- **Fees:** Fees for maintaining the records—including fees for retention and continued access to electronic records.
- **Retention period:** The custodian will keep and maintain the patient records for the required retention period.
- **Legal compliance:** The custodian will comply with state and federal laws governing healthcare record confidentiality, access, disclosure, and charges for copies of the records.
- **Access:** The information contained in the records cannot be accessed without a signed release from the patient or a properly executed subpoena or court order.
- **Release:** Copies of patient records will be released to a person designated by the patient only with the patient's written request.
- **Future considerations:** If the custodian is another practitioner, the agreement addresses any future personal practice decisions (for example, retiring, selling, or moving) and makes provisions to ensure the safety of and continued access to the records by the original practitioner or the practitioner's personal representative.
- **Changes to contact information:** The original practitioner or the practitioner's personal representative will be notified of any change to the custodian's address or phone number.
- **Scope of agreement:** Terms of the agreement apply to everyone in the custodian's employment and facility.

Inventory patient records prior to transfer or storage. The practitioner should retain a copy of the inventory.

For more information, see our *Closing or Relocating a Healthcare Practice* guide at **thedoctors.com/closing-relocating**.

QUICK ANSWERS TO FREQUENTLY ASKED QUESTIONS

Q How long should patient records be kept?

A You must follow federal and state-specific laws or regulations and the requirements of contracted payer plans. If no federal or state statutory or contracted requirements apply, The Doctors Company recommends the following:

- Adult patients, 10 years from the date the patient was last seen.
- Minor patients, 28 years from the patient's birth.
- Deceased patients, five years from the date of death.

Professional licensing boards or associations may also be able to provide information on state statutes, administrative code provisions, policies, or recommendations on record retention.

For a more detailed discussion of record retention, see the Retaining Patient Records section of this guide.

Q Is information stored in other formats—such as videos, x-ray films, ECG recordings, fetal monitoring strips, photos, and dental models/casts—part of the patient record?

A Yes. Regardless of the format, any and all data collected at the time of a patient encounter is part of the healthcare legal document. Retain computerized and physical 3D models used for surgical and dental treatment plans according to the same retention schedule.

Q Does the patient record include financial information, such as billing and insurance data?

A Financial information, including medical and billing records, is part of the designated record set as defined by HIPAA (45 CFR § 164.501, see **ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164#164.501**). Financial information, which should be kept separate from patient care entries, is not part of the legal health record (a subset of the designated record set). Follow a consistent policy on what is released as part of the legal health record for all patients who request a copy of their medical or dental record.

It is recommended that you check with your business attorney or state professional licensing board for details regarding retention laws on billing and insurance records—especially as the laws may relate to Medicare or Medicaid patients. For example, CMS requires Medicare managed care practitioners to retain records for 10 years, and the Internal Revenue Service requires billing records to be retained for seven years.

Q How long should patient telephone calls/messages, email or text messages, and scheduling records be kept?

A The Doctors Company recommends the following:

- Document in the patient record all telephone calls and messages and email or text messages that pertain to patient care, and keep the documentation according to the above-referenced record retention guidelines.
- Keep patient scheduling records for one year.

Q If I obtain copies of records from a patient or another practitioner, am I required to maintain them?

A Review, extract, and copy any information that might be needed from that record for patient diagnosis or treatment. The retained information or documentation is then incorporated into the patient record kept in your office. Be aware that keeping all of the patient's records could make the healthcare professional liable for information related to other specialties. If the information is not used for patient care, destroy it or return it to the source.

Q How should patient records or other associated media (such as photos, digital images, CDs, and films) be destroyed?

A Any destruction method must maintain the confidentiality of the information. The only safe methods for destroying paper records are incineration and shredding. A destruction method for electronic media must render the information unreadable. Simply deleting the record is not sufficient. Use a reputable company to destroy paper and electronic information, models/casts, and equipment, such as computers and copiers. Keep a log of the records destroyed.

Q What are considerations for the long-term storage of inactive patient records?

A Inactive records that have been kept for the required time may be thinned from the active patient cases. Take the following factors into consideration when arranging long-term storage:

- **Privacy:** Will the records be protected from unauthorized persons in a manner that is consistent with federal and state privacy laws?
- **Safety:** Will the records be protected from fire or flood damage and from unauthorized access or theft?
- **Accessibility:** Will the records be easy to retrieve and copy?

Q May I transfer paper records to an electronic format?

A Yes. The factors in the previous question on privacy, safety, and accessibility can also guide you on transferring records to an electronic format. Any PHI transferred or stored electronically must be encrypted. Back up computer data at regular intervals and store it offsite.

Q Is it sufficient to back up a copy of an EHR onto an external storage device or to the cloud?

A Yes, the best practice is to perform a backup every evening to the cloud or to a separate server stored in another physical location. Establish a schedule and periodically assess the backup function. All PHI stored electronically must be encrypted. If you use an application service provider—where your data is stored by the EHR vendor and you access it online—confirm that your contract includes terms that ensure your data will be available to you when you are ready to arrange for long-term storage.

Q May I thin and purge patient records prior to storage?

A Yes. Copies of other healthcare practitioners' records that are not directly related to your care, such as hospital records, may be purged because the originals will be maintained by the hospital. Keep records from other practitioners that are directly related to your care and are maintained as a regular part of your record for the same period that you retain your own records.

Q May I sell my records when I sell my practice?

A Yes. We suggest that you include the recommended retention time and access capability as part of your sales agreement. For more information, see our *Closing or Relocating a Healthcare Practice* guide at **thedoctors.com/closing-relocating**.

Q If I move to another state, may I take my records with me?

A Yes, with the same conditions for retention and accessibility that prevail in a sale. It is reasonable to alert the patients in your active/current caseload about your move to give them an opportunity to request a copy of their records.

Q If a patient requests a copy before I move or close my practice, may I hand over the original record?

A No. The original is the property of the healthcare professional. That individual has a duty to maintain the record. The patient should be given a copy, never the original.

Q Are healthcare professionals allowed to complete record documentation from home?

A The only time an active, original paper patient record should be out of an office is when it is required to be present in a court of law. Any access to electronic records while away from the office must be through an encrypted, HIPAA-compliant format.

Q What should I do if someone claiming to be a representative of a deceased patient's estate requests a copy of the record?

A You must first verify through your own records or from a death certificate that the patient has expired. Then, ensure that the individual requesting the record is a qualified representative of the decedent's estate (for example, the executor). The individual should provide a copy of an official document from the state as proof, and the record request should be in writing and signed by the individual acting as the estate's qualified representative.

See also "Medical and Dental Record Issues: Frequently Asked Questions" at **thedoctors.com/recordfaqs**.

CONTACT US

Your patient safety risk manager can provide expert guidance and support whenever you have questions or need assistance.

CALL 800.421.2368

EMAIL patientsafety@thedoctors.com

VISIT thedoctors.com/patientsafety

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