Legal Issues in Health Care

Tutorial # 4

December 2007

Medical Records

The Role of Medical Records
Medical records play a critical role in the care and treatment of patients and in the practice of medicine.

- Medical records assure the delivery of appropriate and timely medical care to patients.
- Quality assurance programs rely on medical records for information to determine if patient care measures up to specific standards.
- Risk management programs depend upon medical records to identify potential risks so that the risks can be eliminated or minimized.
- Peer review of the qualifications and performance of medical staff members depends largely on information contained in the medical record.
- Payment and reimbursement for health care services require accurate and current data about the nature of these services and the identity of the recipient.
- Medical records play a crucial role in the defense of medical malpractice lawsuits and are often the only line of defense.
- Medical records are a key component in a successful regulatory compliance program and are the best defense against fraud and abuse charges.

Making the Record
Entries should be made at the time of service or soon thereafter and must be dated and signed or initialed. Corrections, clarifications, and the addition of information that was not initially available should be made as soon as possible, preferably within 24 hours of service. Errors must be legibly corrected, dated, and signed or initialed. Deleted items should have only one thin pen line drawn through them. Nothing should be obliterated or removed from the record.

The Joint Commission (JCAHO) strongly recommends against using abbreviations, acronyms, and symbols that may create confusion and compromise patient care. JCAHO publishes a minimum "Do Not Use List," and many facilities create their own much longer "Do Not Use List," to protect their patients from avoidable, and sometimes fatal, mistakes.

Health care personnel should be familiar with their facility's "Do Not Use List," as well as with the facility's protocol for creating, correcting, and clarifying a medical record. The Compliance Officer is a good resource for this information.

Consequences of Poor Record Keeping
The quality of a medical record depends upon the people making the entries. Illegible, incomplete, inaccurate, or untimely entries may have serious consequences, not the least of which may be substandard patient care. The medical record is often the best line of defense in a medical malpractice lawsuit, But, incomplete records may also allow a jury to fill in the gaps and find liability. Incomplete records may also allow a third party payer to disallow charges on a bill that are not supported by the medical record, as well as subject the

provider to possible charges of fraud and abuse. An inaccurate record may allow a jury to disregard the entire record. A falsified record may allow a jury to infer a "consciousness of negligence." Mailing a falsified record may result in criminal charges of mail fraud. Improperly kept records can put a facility at risk of losing its licensure, accreditation, and eligibility to participate in federal reimbursement programs.

Confidentiality
Confidentiality requirements impose additional obligations on health care personnel to know when to release medical records, how much information to release, and to whom a medical record may be released. Both state and federal law impact the answers to these questions.

Tennessee recognizes a "covenant of confidentiality," that imposes an obligation on health care providers to maintain a patient's confidential health information. The Patient's Privacy Protection Act requires licensed health care facilities to protect a patient's right to privacy for care received at the facility. For a more detailed discussion of Tennessee law, see the factsheet "Confidentiality" Tutorial #2.

The Health Information Portability and Accountability Act (HIPAA) is a federal law designed to protect patient privacy. HIPAA's Privacy Rule prohibits health care providers from disclosing a patient's protected health information (PHI) unless authorized by the patient, by the patient's representative, or by law. HIPAA's Security Rule requires health care providers to ensure the confidentiality, integrity, and availability of all electronic protected health information (ePHI) that the provider creates, receives, maintains, or transmits.

Permitted Disclosures without Patient Authorization.
HIPAA allows health care providers to disclose PHI without patient authorization for the following purposes.

- Treatment,
- Payment, and
- Health care operations (such as training, education, peer review, risk management, etc.).

The "minimum necessary standard" must be met in disclosing PHI without patient authorization for purposes of payment or health care operations. The minimum necessary standard requires the health care provider to limit the PHI disclosed to the minimum amount necessary to accomplish the disclosure's purpose. There is no limit on the amount of PHI that may be disclosed for treatment purposes among health care providers.

An incidental disclosure of PHI that occurs during a permitted disclosure does not violate HIPAA if it meets the minimum necessary standards and reasonable safeguards have been taken to protect the PHI. For example, a white board at the nursing station that lists patient names, scheduled procedures, and orders for patient care does not violate HIPAA if reasonable safeguards have been taken to shield the information from the casual passerby.

HIPAA defers to state laws that require health care providers to make reports to law enforcement authorities or other governmental agencies. For example, if state law requires a health care provider to report a suspected case of child abuse to the Division of Children's Services, the health care provider is not violating HIPAA by making the required report. HIPAA also defers to any state law that is more protective of PHI.

Sanctions for HIPAA Violations.
HIPAA violations have serious consequences. An unintentional disclosure of PHI that is not permitted by law without patient authorization carries a civil fine of up to $25,000 per year. An intentional disclosure of PHI that is not permitted by law without patient authorization carries a criminal penalty. Fines can range from $50,000 to $250,000 and prison sentences can range from one to ten years.

Ownership of the Records
Generally, the health care provider owns the original medical record subject to the patient's interests. The patient has the right to request copies of the record, and in Tennessee, the physician must provide a copy within ten days of a written request. If the patient sees an error in the record, he or she has the right to request a correction. However, the provider is not obligated to make the correction unless the provider agrees that a correction is appropriate. The patient also has the right to restrict access by others and to learn how the records have been accessed.

Retention of Records
State law may require that health care providers keep medical records for a minimum period of time. Under Tennessee law, the patient medical record must be kept for ten years from the last professional contact with the patient. The medical record for minors must be kept for one year after they reach the age of majority or ten years after the last patient contact, whichever is longer. Hospitals must keep and preserve records that relate directly to the care and treatment of a patient for the same time period following the date of discharge. Some records must be kept indefinitely, such as records for an incompetent person, and immunization records for all patients. X-rays, radiographs, and other imaging products may be destroyed after four years, but only if there is a separate report interpreting the images. Mammography records must be kept for twenty years. Patient records that are the subject of a dispute must be kept until the dispute is resolved, or the above rules have been met, whichever is longer.

The American Medical Association (AMA) takes the position that physicians have an obligation to retain patient records which may reasonably be of value to a patient. According to the AMA, medical considerations should be the primary basis for deciding how long to retain records. Old records that are discarded must be destroyed to preserve confidentiality. Before destroying them, the AMA recommends giving patients the opportunity to claim the records or to have them sent to another doctor, if feasible.

Tennessee has statutorily defined procedures for destroying medical records. Records must be destroyed in the ordinary course of business by burning, shredding, or other effective methods for preserving the confidential nature of the records. The time, date, and circumstance of the destruction must be noted, and the record of destruction must be sufficient to identify which group of destroyed records contained a particular patient's records. A medical record cannot be singled out and destroyed except in accordance with established office procedures for destroying medical records.

Conclusion
Good documentation of patient care is a skill that should be cultivated by all health care providers. Not only does it assist in providing quality health care to the patient, but it serves as the primary basis for reimbursement, legal, and regulatory actions.

Written by: Carol A. Schwab, J.D., LL.M., Director of Medical/Legal Education, Professor, College of Pharmacy, University of Tennessee Health Science Center, Memphis, TN.