MEDICAL RECORDS

The Front Desk clerk assigned to Filing will assist providers with requests for information from insurance companies, attorneys, and patients themselves. Providers may refer requests to him or her at the health center. The filing clerk will retrieve the chart and prepare the paperwork for the provider's completion and signature.

Sample Signatures

The Medical Records Administrator will keep a log of sample signatures for our records. The sample signature requested from provider should be signed the way provider intends to sign all of their charts. The sample signature log will be compared to any patient's record to identify the provider when necessary.

Should provider, for any reason, change their signature during their employment with , must give the Medical Record Department a revised sample signature.

Standards for Confidentiality of Health Information

There are written standards for the confidentiality of Medical Records. Some of the most relevant points are:

- Medical records are the property of Medical Center Inc., under the custodial care of the Medical Records Administrator.
- Security. The Front Desk controls access to all records in its custody. The Medical Director or his designee must authorize the removal of medical records from the premises to non-agency sites.
- Accessibility. Only authorized personnel for whom the need has been established shall have access to medical records. All personnel must at all times exercise extreme caution to prevent disclosure of health information to unauthorized persons in the service areas.
- Release of Information. The Medical Record Administrator is responsible for the release of all medical information. Therefore, send all requests for information from the medical record to the Front Desk Personnel's attention.
- The patient shall not have access to his/her medical record unless the Medical Director or his designee authorizes it. When concern for a patient's health makes it inadvisable to give him/her access to the medical record, it will be made available to the person legally authorized by the patient or the person to be notified in the event of an emergency. The Medical Director and/or the Medical Records Administrator should be consulted if there are any questions.
- The patient must be completely aware of any request for information from lawyers and insurance companies. The patient must sign a consent form specifying the name of the requesting agency and the type of information needed and dated within a ninety-day period.
- Special consent forms are used for release of information of drug and alcohol records, and HIV-related information. Do not give any information over the phone to anyone asking about patients who have these conditions. Persons convicted of violating this law may receive heavy fines and/or jail sentences.

Organization of the Medical Record

health records are organized to have certain items in a specific order on the left and right sides of the typical bi-folding chart:

- On the left side are the preventive care flow sheets, disease management flow sheets, patient registration data, and consent-to-treat forms, problem flow sheets, and medication flow sheets.
- On the right side of the chart are the progress notes (most recent on top), laboratory results (filed with most recent on top), radiology results, correspondence from outsiders, usually consultation reports or hospital discharges, referral forms and requests for records.
- Health Check form are done periodically on children from infancy through 20 years of age. These forms are filed on the right side of the chart under the tab Physical with the most recent on top.

Recordation

- EVERY encounter needs an entry in the medical record. Billing for episodes of care not documented in the health record is considered by many to be fraudulent billing. Our medical records are subject to audits that compare reimbursements by various entities to medical record entries in order to test for accuracy and appropriateness of billing.
- Providers should summarize all applicable information from hospitals, etc. to include diagnoses, procedures, etc. in progress notes and the problem list (at a minimum).

Progress Note Essentials

The progress note must include:

1. Date of entry and Chart number
2. Chief complaint or purpose of visit;
3. Objective findings;
4. Diagnosis or medical impression;
5. Studies ordered such as laboratory or x-ray;
6. Therapies administered (medications should be placed on the med flow sheet);
7. Disposition, recommendations and instructions to patients;
8. Practitioner's signature
9. Practitioner's name
10. Discharge instructions to the patient (generally completed by ancillary staff).

Medical Record Completeness

The following two tables illustrate critical components of the medical record along with descriptions and requirements.

Medical Record Component	Description and Requirements	Vigilance Functionality	Documentation Functionality
Problem Flow Sheet "Interactive"	1. An Interactive Problem Flow Sheet must illustrate an ongoing accurate and up-to-date listing of all medical problems diagnosed by practitioners. 2. The Problem Flow Sheet must illustrate all medical problems diagnosed by non-practitioners and made known to through reviews of consultation reports, hospital discharge summaries, and other pertinent sources made a part of the medical record.	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Medical assistants; Nurses; Doctors; and, Midlevel providers
Medication Flow Sheet "Interactive"	1. An Interactive Medication Flow Sheet must illustrate an ongoing accurate and up-to-date listing of medications prescribed by practitioners. 2. The Medication Flow Sheet must illustrate all medications prescribed by non- practitioners and made known to through reviews of consultation reports, hospital discharge summaries, and other pertinent sources made a part of the medical record.	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Medical assistants; Nurses; Doctors and Midlevel providers
Drug Allergy Notation	1. The Medication Flow Sheet has a section in the right upper corner that is reserved for Drug Allergy notation. 2. This section must illustrate accurate and up-to-date information on drug allergies.	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers
Immunization Record Summary Sheet "Interactive"	1. An Interactive Immunization Record Summary Sheet should illustrate an ongoing accurate account of vaccinations administered to the patient by staff. 2. The Immunization Record should illustrate an accurate and the best account of vaccinations administered to the patient by non-practitioners.	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Pediatric or Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers

Medical Record Component	Description and Requirements	Vigilance Functionality	Documentation Functionality
Growth & Development Chart Summary Sheet (pediatric patients) **"Interactive"**	An Interactive Growth & Development Chart Summary Sheet should illustrate the majority of heights and weights that were documented in the progress note or on the Health Check form performed by medical staff on the pediatric patients.	Medical record technicians; Pediatric Coordinator; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Pediatric or Unit Coordinator; Medical assistants; Nursing staff; Doctors, and Midlevel providers
"Missed Appointment" Documentation of Action Plan	1. For each "missed appointment" by a user, the appointed provider is responsible for reviewing the medical record and determines an appropriate action plan. 2. The action plan must be documented in the medical record. 3. Use of the "missed appointment" stamp is strongly advised in addressing missed appointments. 4. Lack of a "missed appointment" stamp in the clinical area is no waiver against documenting an action plan.	Front Desk staff	Midlevel providers and Doctors.
"SOAP" Medical Record Documentation	Each SOAP note must be signed-off by the practitioner.	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Doctors, Midlevel providers
Supporting Medical Information Included in the Medical Record	1. Supporting medical information includes radiology reports, consultation reports, hospital discharge summaries, and previous medical records from former doctors. 2. All supporting medical information included in the medical record must be signed or initialed by the practitioner principally involved in the care of the patient and, at a minimum, the practitioner who ordered the consultation or procedure.	Medical record technicians; Unit coordinators; Medical assistants; Nursing staff; Doctors, and Midlevel providers	Doctors, midwives and midlevel providers

Without a doubt, the doctor has the highest authority and responsibility to ensuring medical record completeness. However, all staff members with medical record clearance (Medical Record Technicians, Unit Coordinators, Medical Assistants, Nurses, Midlevel Providers, and Doctors) are charged with *vigilance functionality.* When a medical record documentation deficiency is detected through *vigilance*, the chart should be returned to and/or corrected by the first staff person (from left to right in the table below) who has the responsibility and authority to remedy the documentation problem.

MEDICAL RECORD COMPLETENESS CHECKLIST	**WHO HAS AUTHORITY TO CORRECT A RECORD DEFICIENCY IS CHECKED BELOW IN THE APPLICABLE COLUMN**					
VIGILANCE ITEM	**Medical Record Technician**	**Unit Coordinator**	**Medical Assistant**	**LPN or RN**	**Midlevel Provider**	**Doctor**
1. Is the Problem Flow Sheet Interactive?			✔	✔	✔	✔
2. Is the Medication Flow Sheet Interactive?			✔	✔	✔	✔
3. Is the Drug Allergy Notation on Medication Flow Sheet Interactive?	✔	✔	✔	✔	✔	✔
4. Is the Growth & Development Chart Summary Sheet Interactive? (Pediatrics)			✔	✔	✔	✔
5. Is the Immunization Record Summary Sheet Interactive?			✔	✔	✔	✔
6. Is the SOAP progress note signed-off by the practitioner?					✔	✔
7. Is the "Missed Appointment" action plan documented?					✔	✔
8. Are all Supporting Medical Information (radiology reports, consultation reports, and hospital D/C summaries) recently added to the Medical Record signed-off by the practitioner?					✔	✔
9. Are all new Medical Diagnoses highlighted in Supporting Medical Information reflected on the Problem Flow Sheet?			✔	✔	✔	✔