Improving The Physician's Report Card

Medical Record Documentation Standards for Physician Offices

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One way a physician can ensure a more successful future in managed care is to document his medical records properly. Although his patients may consider him a good doctor, he may not be recording his charts according to industry standards, and, thus may receive a poor grade on his "report card." Yes, it seems demeaning for physicians to be relegated to being students again, by receiving "grades," but welcome to managed care! In order for a doctor to succeed in this day and age, he or she must be accountable to the public. Since the days of Hippocrates, the physician has always been expected to be more responsible than other professionals for his or her own actions, and that is true now more than ever.

The medical profession is under attack by the public. Now that physician profiles as well as "score cards" of hospitals are reported to the public, managed care organizations (MCOs), including health maintenance organizations (HMOs) that are evaluated by the National Committee for Quality Assurance (NCQA) must have the results reported to the public, so that people will have a choice to select their own doctor, hospital, or HMO health plan when they become ill.

NCQA, an independent not-for-profit Washington -based organization that conducts voluntary surveys that assess and report to the public on the quality of managed care plans, has only passed one-third of the health plans that it has reviewed. Thus, most of the HMOs have failed the accreditation reviews, primarily, due to substandard documentation of their office charts by physicians. Some states, including Florida, require that HMOs be accredited by NCQA in order to do business in their state. More states are joining the parade.

Physicians should take advantage of this marketing approach to improve their medical practice by documenting their charts accurately. This would attract more and better contracts with HMOs. NCQA has recently expanded the scope of the voluntary evaluation programs to include medical groups and independent practice associations (IPAs), a rapidly evolving segment of the healthcare industry, estimated to be approximately 19,500 physician groups. This would streamline NCQA's accreditation process for the multiple MCOs and HMOs by substituting a single NCQA screening of each participating physician organization for the overlapping and multiple annual reviews of the physicians by the various HMO's in the doctor's offices. The AMA is also planning a certification program of physician quality and competence providing a "Seal of Approval" as a mark of good practice, hoping to eliminate the multiple office reviews demanded by managed care plans. The physician would then have only one report card, instead of multiple ones required by each individual HMO requesting an accreditation survey. Naturally, it would behoove the physician to have a high score, early on, to expand his marketability as a good physician.

NCQA standards for medical record documentation in the physician's office cover six areas: legal aspects, basic record keeping, baseline data, continuity of care, prevention of disease, and pediatric issues. These standards are covered in an interactive educational computerized program available on CD-ROM as well as on the Internet at http://www.aimlaw.com. It is approved for three CMEs in risk management for physicians. Physicians can access them from any computer, at any time. Those unfamiliar with using a computer can go to a business supply or copy center where, for a small fee, a technician can assist and guide him through the program. It is an easy and fun way to learn. It is less boring than reading a book, or listening to a didactic lecture because he or she interacts with the material and actually participates in the learning process.

Legal aspects

The medical record serves as a legal basis for planning patient treatment that provides continuity of care in the on-going assessment of treatment of the patient's condition. It furnishes documentary legal evidence of the course of the patient's evaluation, treatment and change in condition, as well as records communi-

cation between the primary physician and consultants. The chart provides a written record of the patient's medical history and treatment, protecting the legal interests of both the physician and patient. It also assists in securing prompt and accurate payment for services rendered, by proving that care was provided.

The medical chart is a legal document and admissible in court as evidence. Everything written in the record is legally important.

Legal informed consent

Physicians should not undertake a course of treatment on a patient without proper and legal informed consent. The elements of informed consent - general discussion of the patient's illness, interpretation and meaning of the diagnostic tests, the alternative viable methods of diagnostic tests and treatment with the explanation of benefits and risks - should be documented in the chart. Although informed consent, a relationship between the physician and patient that shares risk and need not be in writing, it should be documented and recorded as part of the record. Most juries would not believe that the patient was ever informed and gave consent if he claimed he could not remember approving a particularly important event. The medical chart is a legal document and admissible in court as evidence. Everything written in the record is legally important. Also, an important event in the course of treatment that is not documented in the chart is interpreted by the jury to have never occurred legally.

Confidentiality - exceptions

The general rule is that medical records may not be furnished to, nor the medical condition of the patient discussed, with any person other then the person's legal representative or other healthcare providers involved in the care or treatment without the patient's written authorization. This rule, however, has a number of exceptions which create many problems involving complex, legal, social, and public health issues. Both plaintiffs and defendants frequently seek to subpoena medical records in civil disputes, other then medical malpractice, which may include personal injury, product liability, auto accidents, divorce proceedings, etc. Other parties frequently seek medical records, such as employers, and insurers of health, life and disability. Also, public health departments have on going needs for medical information, especially concerning communicable diseases. The medical chart may contain important information helpful (or harmful) in the courtroom as legal evidence in those cases. Although, the Hippocratic Oath and the AMA Code of Medical Ethics speak of the physician-patient *privilege*, it may be an ethical or moral privilege, but it is not a legal privilege in most states. However, this means that evidence concerning moral or ethical issues may not be admissible in court. The medical record is admissible as evidence in other lawsuits, not necessarily involving the treatment of the patient, but useful in other court cases. It is important to document events accurately and honestly in the chart, as the exception to the general rule of confidentiality allows easy access of the medical record to the courtroom.

Patient requests for records

Who owns the medical record? This is a question often asked by physicians and patients alike. The original record belongs under the care and custody of the facility where the record was created. This may be a physician's office, hospital, managed care organization, nursing home, etc. Patients, however, are entitled to a copy of their records. Upon request, records must be furnished in a "timely manner," without delays for legal review. Records include copies, (not originals) of all records of examination and treatment, including X-rays, insurance, and other financial information. A physician must not make a record release contingent upon payment of past due bills for professional services rendered. However, the physician may request payment for the reasonable cost of reproducing the records as a condition of release.

A good rule of thumb is to maintain records for at least the statute of limitations period for medical malpractice lawsuits in your state.

Record retention

All states require that medical records be maintained for a specified period of time. For example, practicing physicians in Florida are required to maintain their medical records for a minimum of five years. Community standards, individual patient needs, and policies of malpractice insurance carriers may necessitate longer retention periods. A good rule of thumb is to maintain records for at least the statute of limitations period for medical malpractice lawsuits in your state. A lawsuit could not be properly defended if the physician has already discarded the medical record. State law or the appropriate specialty societies may establish retention requirements for special items, such as X-rays or pathology slides.

Electronic medical records

Computer-based medical records are growing in popularity and becoming an acceptable alternative to the traditional paper-based record. Patients are entitled to the same degree of security and confidentiality that is given paper-based records. Any facility

using computerized records, or considering converting to an electronic system should keep in mind that record retention requirements are the same as for paper records. In order to defend malpractice suits, records should be maintained in some form until the statute of limitations for malpractice expires. Security is an important concern in electronic records, and efforts to maintain privacy will be an important issue as technology improves.

Alterations

Physicians dread being sued for malpractice. The financial and emotional drain can be devastating. A physician may sometimes behave irrationally when fearful of an impending lawsuit. One of the most foolish and irrational acts for a doctor is to put an improperly dated late entry into the medical record. Physicians make these late entries hoping that the record will appear less incriminating. Undated or backdated entries suggest a fraudulent attempt to alter the record. Expert document and handwriting analysis will usually detect the vast majority of late entries.

Legibility of the medical record

Poor legibility remains a problem with many physicians' hand written medical records. Anything worth writing should be written in a clear and legible fashion. State medical boards require that records are maintained in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken or not undertaken. Third party payers are increasingly denying payment for services rendered when their utilization review reveals illegible records. Physicians sued for malpractice are at a distinct disadvantage when their records are illegible. Plaintiffs' attorneys will enlarge portions of the record with the worst handwriting and display them to the jury. Even the best physician can be made to appear uncaring when his records are unreadable.

Basic record keeping

Some form of patient identification must be on every page of the medical record. The basic requirements include the patient's name and identifying number. This number may be their date of birth, social security number, or a case number the office has assigned. While not required, it is even better to put more information on each sheet such as gender, date of birth, social security number **and** case number. Biographical data must be recorded and updated as needed. This should include name, age, sex, marital status, home address and phone number, occupation and business phone number, next of kin (for emergencies), social history, family history, list of medical problems, list of medications, and advance directives.

The medical record must be legible to someone other than the author. The person who rates the documentation of the quality of care may not give the physician credit for something he cannot read. Therefore, if the handwriting is illegible, the doctor could conceivably fail a medical records audit, even though he gave quality care to his patients. In some instances, legibility played a big part in the opposing attorney's ability to prove a physician was sloppy in his documentation, thus, causing the jury to assume the physician was sloppy in the care of the patient. While the outcome of the patient's illness may not depend on penmanship, the success or failure in a malpractice lawsuit may well depend upon the legibility of the physician's handwriting. The doctor's signature and title must also be legible. The title of any other person documenting in the record must also be present. All physician assistants' and nurse practitioners' documentation must be co-signed by the doctor. If the signature of the physician cannot be read, he should sign his name and then print it, or use a stamp with his name printed underneath his signature. Only acceptable abbreviations should be used in the documentation.

Baseline data are basic items which contribute to a complete biographical health sketch on which to base an individualized plan of care for each patient. Baseline data includes a complete history and physical examination, medical/surgical history, family history, medications, immunizations, and a problem list. It is strongly suggested that an adequate initial baseline history and physical examination be documented in the chart within 90 days of the first visit, or by the third visit, whichever comes first. The medical history can be documented on a pre-printed form that the patient can fill out. The physician should sign and date the history to document that he/she has reviewed the information.

The primary care physician is responsible for maintaining a unified, organized, and chronological record for each patient. This

CAN YOU PASS THE TEST?
NCQA MEDICAL RECORD REVIEW

1. Do all pages contain patient ID?
2. Is there biographical/personal data?
3. Is the provider identified on each entry?
4. Are all entries dated'?
5. Is the record legible?
6. Is there a completed problem list?
7. Are allergies and adverse reactions to medications prominently displayed?
8. Is there an appropriate past medical history in the record?
9. Is there documentation of smoking habits and history of alcohol use or substance abuse?
10. Is there a pertinent history and physical exam?
11. Are lab and other studies ordered as appropriate?
12. Are working diagnoses consistent with findings?
13. Are plans of action/treatment consistent with diagnosis (es)?
14. Is there a date for return visit or other follow-up plan for each encounter?
15. Are problems from previous visits addressed?
16. is there evidence of appropriate use of consultants?
17. Is there evidence of continuity and coordination of care between primary and specialty physicians?
18. Da consultant summaries, lab, and imaging study results reflect primary care physician review?
19. Does the care appear to be medically appropriate?
20. Is there a completed immunization record?
21. Are preventive services appropriately used?

will provide continuous, complete evidence of all health care services rendered. Progress notes should be dated, signed, and arranged in a chronological order. The most current note should be first. The notation should contain the following elements: chief complaint or reason for visit, subjective & objective findings, identification of the problem, plan of treatment, unresolved problems from prior visit, and return visit.

All hospital admission, discharge, and emergency visit summaries must be in the medical record within 30 days of discharge. Each summary should be acknowledged by a signature and date. Any necessary follow up should be indicated in the progress notes. The reports of all consultants must be placed in the medical record, signed and dated. Discussion with the patient regarding the consultant's findings and recommendations must be documented in the progress notes. Evidence of unsuccessful attempts to reach the patient by phone should also be documented. Some regulatory agencies may require the actual request or referral form for the consultation in the medical record as proof that it was requested and approved. Check for the state's requirements.

Laboratory results and other diagnostic reports such as x-rays, CT scans, and ECGs must be placed in the medical record in chronological order. Each report must be acknowledged by signature of the physician and date. It is a good practice to place notification of abnormal results and plan of treatment in the progress note. Attempts to reach the patient by phone to inform him of abnormalities should also be documented. If a letter is sent to the patient regarding the results, or requesting the patient to return to the office, a copy of the letter should be in the medical record. A notation of the date and content of the letter may be made in the progress note as an alternative.

Any refusal of services should be documented in the medical record. Some physicians make it a practice to have the patient sign the progress note if an examination is refused. "Refused" and "deferred" are not considered synonymous. A notation such as "deferred at this time" is not acceptable without an explanation of why the examination was deferred, and whether the examination will truly be done at another time. Age appropriate preventive services, health risk assessment, and appropriate education, should be evidenced in the medical record.

Reports of ancillary services such as physical therapy, rehabilitation, home health, and nutritional counseling must appear in the medical record. Each report must be acknowledged by signature of the physician and date. The reviewer will check the progress notes to see whether ancillary services received correspond to the referrals made in the plan of care. Patient compliance or non-compliance with the plan of care, medication, and follow up visits to the physician and consultants should be documented in the progress note.

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