

MEDICAL CHARTS



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BIOGRAPHICAL STATEMENT

James A. Christopherson of Dingeman, Dancer & Christopherson, PLC represents physicians, healthcare organizations, physician organizations and ambulatory surgery centers. His practice includes advising clients regarding compliance issues, mergers, employment issues, corporate issues including formation and succession issues and tax exempt legal issues. He practices in the area of healthcare law, commercial litigation and alternative dispute resolution. He received his B.A., *magna cum laude*, from Michigan State University, and his J.D. degree, *cum laude*, from Wayne State University School of Law, where he received an American Jurisprudence Award and the Silver Key Certificate. He is a member of the State Bar of Michigan and is admitted to practice before the United States Supreme Court (where he has personally argued), the United States District Courts for the Eastern and Western Districts of Michigan, and the United States Court of Appeals for the Sixth Circuit. He is a member and former president of the Grand Traverse-Leelanau-Antrim Bar Association. He is a member of the American Health Lawyers Association, the Health Care Law Sections of the State Bar of Michigan and the American Bar Association and several committees and working groups. He is a frequent author and speaker on healthcare issues. He has authored several law review articles including "Physician / Hospital Joint Ventures in the Wake of St. Davids" (Journal of Health Law, Winter 2004, Volume 37, No.1), "Buyer Beware When Purchasing a Medical Practice" (Michigan Health Law Report, Summer 2002) and "The Captive Medical Malpractice Insurance Company Alternative" (Annals of Health Law, Volume 5, 1998).

I. MEDICAL CHARTS: CLINICAL v LEGAL

Definition – A medical chart is a confidential document that contains detailed and comprehensive information on an individual and the care experience related to that person. Only patient notes, correspondence, test results, consent forms, and the like belong in the patient's chart. Correspondence to your malpractice carrier, peer review notes, general notes, and other items should not be stored in patient charts.

Purpose – The purpose of a medical chart is to serve as both a medical and legal record of an individual's clinical status, care, history, and caregiver involvement. The specific information contained in the chart is intended to provide a record of a person's clinical condition by detailing diagnoses, treatments, tests and responses to treatment, as well as any other factors that may affect the person's health or clinical state.

Demographics – Every person who has a professional relationship with a health-care provider has a medical record. Because most people have such relationships with more than one health professional or caregiver, most people actually have more than one medical chart.

It is important that the information in the chart be clear and concise, so that those utilizing the record can easily access accurate information. The medical chart can also aid in clinical problem solving by tracking an individual's baseline, or status on admission or entry into an office or health care system; orders and treatments provided in response to specific problems; and individual responses. Another reason for the standard of clear documentation is the possibility that the record may be used in legal proceedings, when documentation serves as evidence in exploring and evaluating a person's care experience. When medical care is being referred to or questioned by the legal system, chart contents are frequently cited in court. For all of these purposes, certain practices that protect the integrity of the chart and provide essential information are recommended for adding information and maintaining the chart. These practices include the following:

- Date and time should be included on all entries into the record.
- A person's full name and other identifiers (i.e., medical record number, date of birth) should be included on all records.
- Continued records should be marked clearly (i.e., if a note is continued on the reverse side of a page).
- Each page of documentation should be signed.
- Blue or black non-erasable ink should be used on handwritten records.
- Records should be maintained in chronological order.

- Disposal or obliteration of any records or portions of records should be prevented.
- Documentation errors and corrections should be noted clearly, i.e., by drawing one line through the error and noting the presence of an error, and then initialing the area.
- Excess empty space on the page should be avoided. A line should be drawn through any unused space, the initial, time, and date included.
- Only universally accepted abbreviations should be used.
- Unclear documentation such as illegible penmanship should be avoided.
- Contradictory information should be avoided. For example, if a nurse documents that a person has complained of abdominal pain throughout a shift, while a physician documents that the person is free of pain, these discrepancies should be discussed and clarified. The resolution should be entered into the chart and signed by all parties involved in the disagreement.
- Objective rather than subjective information should be included. For example, personality conflicts between staff should not enter into the notes. All events involving an individual should be described as objectively as possible, i.e., describe a hostile person by simply stating the facts such as what the person said or did and surrounding circumstances or response of staff, without using derogatory or judgmental language.
- Any occurrence that might affect the person should be documented. Documented information is considered credible in court. Undocumented information is considered questionable since there is no written record of its occurrence.
- Current date and time should be used in documentation. For example, if a note is added after the fact, it should be labeled as an addendum and inserted in correct chronological order, rather than trying to insert the information on the date of the actual occurrence.
- Actual statements of people should be recorded in quotes.
- The chart shouldn't be left in an unprotected environment where unauthorized individuals may read or alter the content
- Avoid including witticisms or personal comments ("This patient is a grouch!") in medical records. Things that seem amusing to you at the time you write them may not be funny to a potential jury.

- Avoid changing an entry in order to tone down an overly critical observation of a patient's personality or behavior. "Cosmetic" changes are not necessary for patient care and should not be made at any time.

HIPAA Implications

HIPAA provides patients with the right to request an amendment to their medical records. It does not, however, give them the right to make unfettered changes. You should have a form for patients to complete describing the correction they are requesting; you then have the right to accept or refuse the proposed change. Your decision should be well documented, and may include a comment to the patient's requested change to the record.

Any HIPAA amendments should then be placed in the patient chart in chronological order. Under no circumstances are patients permitted to make changes directly on the medical record. Thus, patients are not permitted to cross out your notes and write in their own.

II. ALTERATION AND DESTRUCTION OF MEDICAL RECORDS

A frequently asked question is whether medical records can be altered, and if so, in what manner. At first glance, the obvious answer would be "no." However, upon further reflection, changes may need to be made in order for the record to be accurate. For example, there may have been an error when a Health Care Provider's ("HCP") notes were transcribed, or an error may have been made when a patient's medical information was inputted into a computer database. In each case, there is a right way and a wrong way to handle these types of issues. In Opinion 6819 by the Michigan Attorney General, it was stated:

It is my opinion, therefore, that section 20175 of the Public Health Code provides that a hospital may not permit a doctor, even with the agreement of the patient, to change patient medical records unless the change is a supplementation or correction that does not conceal or alter a prior entry.

A. OWNERSHIP OF MEDICAL RECORDS

At the outset, it is important to determine who owns the medical records of a patient. According to a somewhat dated opinion from the Attorney General, the physical record belongs to the HCP subject to the patient's right of access to the medical records or the patient's right to receive copies of the medical records. 1978 Opinion of the Michigan Attorney General No. 5125, May 30, 1978. This position, however, does not account for the fact that medical records are becoming increasingly computerized and stored on databases accessed by multiple HCPs. In such instances, who owns the records become less clear.

B. ALTERATION OF PATIENT RECORDS UNDER MICHIGAN LAW

1. General Rules.

By law, HCPs are charged with taking precautions to assure that the medical records are not wrongfully altered or destroyed. This provision does not bar any alterations, only those that are wrongful. As mentioned above, there may be instances where a modification to the record is required to ensure that it is accurate.

In some instances, an HCP and patient may agree that a medical record needs to be modified. However, there is authority stating that a hospital may not permit a doctor, even with the agreement of the patient, to change patient medical records unless the change is a supplementation or correction that does not cancel or alter a prior entry. 1994 Opinion of the Michigan Attorney General No. 6818, September 15, 1994.

2. What to do/ not do

- a. If making changes, do not use white-out or erasers in medical records, and avoid blacking out any portion of the record.
- b. Do not replace pages or rewrite entire entries.
- c. Do use supplements to correct errors in the record.
- d. If you have to delete an entry, make a simple one-line strike through, and label, date and initial the correction.
- e. Do make changes in a timely fashion.
- f. Do note any new entries.

3. Computer Records

- a. By their nature, such records are subject to continuing alteration.
- b. Such records should not be subject to continual alteration. Rather, the records should be authenticated and then no further changes made to them. As noted above, the records can be supplemented if errors or omissions are later discovered. However, this should be done in a timely fashion.

4. Civil liability for Alteration of Medical Records

While there are no published cases on the matter, at least one panel of the Michigan Court of Appeals has recognized that there may be a private cause of action against a hospital or an HCP for alteration of medical records. Wilson v Sinai Grace Hospital. In addition, some other jurisdictions have even gone so far as to permit the award of punitive damages. Perhaps more significant is the adverse inference that a court may allow to be drawn with respect to records that are wrongfully altered.

5. Criminal/Administrative Liabilities

a. A hospital which is found to have wrongfully altered or destroyed medical records is subject to a civil fine of \$10,000.00. MCL 333.20175(2).

b. An HCP or other person, knowing that the information is misleading or inaccurate, shall not intentionally, willfully, or recklessly place or direct another to place in a patient=s medical record or chart misleading or inaccurate information regarding the diagnosis, treatment, or cause of a patient=s condition.

1. An HCP who intentionally or willfully violates this is guilty of a felony.

2. An HCP who recklessly violates this is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year, or a fine of not more than \$1,000.00, or both.

c. Examples

i. There is at least one reported instance of a physician convicted of a misdemeanor attempted alteration of medical records.

ii. In 2000, a doctor's license was suspended for 3 months after it was determined that he had a surgical consent altered and an office visit notation fabricated.

III. MICHIGAN'S MEDICAL RECORDS ACCESS ACT

A. When presented with a request for medical records by a person, a health care provider ("HCP") cannot inquire about the reason for the request.

- B. The HCP must respond within either 30 days, if the records are on-site, or 60 days if the records are off-site.
- C. The response can take several forms.
 - 1. Records can be made available for inspection or copying.
 - 2. The HCP can contact the medical records company retaining the records to have them made available for inspection or copying.
 - 3. If the records do not exist or cannot be located, the patient must be so advised.
- D. An HCP can extend the time to respond by up to 30 days provided it notifies the person in writing. It may not make more than 1 extension per request.
- E. Under limited circumstances, the HCP can refuse to provide the records. If disclosure is “likely to have an adverse effect on the patient,” the HCP can notify the patient in writing and have the records provided to a HCP, facility or attorney of the patient’s choosing.
- F. If the records were compiled by the HCP under a confidentiality agreement, the HCP can deny the request if the disclosure “would be reasonably likely to reveal the source of the information.”
- G. Fees.
 - 1. \$20 initial fee per request.
 - 2. \$1 per page for the first 20 pages.
 - 3. 50¢ per page for pages 21-50.
 - 4. 20¢ per page for pages 51 and beyond.
 - 5. Postage and shipping costs.
 - 6. Costs incurred in retrieving medical records that are 7 years old and older and not maintained or accessible on site.
- H. The HCP can condition compliance on receipt of the applicable fee. Beginning in 2006, the fee shall be adjusted based upon changes in the Detroit consumer price index.
- I. If the patient is “medically indigent,” the HCP must waive all fees as to the first set of copies. “Medically indigent” generally includes those persons receiving Social Security benefits or who have applied for medical assistance

from the State of Michigan. An HCP cannot charge the medically indigent patient the \$20 initial fee.

- J. While the title of the Act indicates that it merely addresses the same issues that are already the subject of exhaustive federal and state regulation, its provisions do address an area of uncertainty confronting HCPs. With the passage of the Act, HCPs no longer have to speculate whether the fees they are charging persons requesting medical records are reasonable.
- K. Due diligence should be exercised in attempting to locate requested medical records. In the event records are missing, the requesting party should be promptly notified. The alteration or destruction of a medical record by an HCP for purposes of concealing responsibility for a patient's injury is a felony. MCLA 750.429a.
- L. Violation.
 - 1. \$1,000 fine.
 - 2. Misdemeanor.
 - 3. Criminal penalties.
- M. What Records Must Be Produced.

A commonly asked question among HCPs is what medical records must be produced by the provider. Many providers take the position that only the records generated by that provider need be produced.

Many providers take the position that there was never a release from the other providers who generated the records. The Medical Records Access Act of 2004, however, defines "medical record" very broadly to include:

...information oral or recorded in any form or medium that pertains to a patient's healthcare, medical history, diagnosis, prognosis, or medical condition and that is maintained by a healthcare provider or health facility in the process of the patient's health (emphasis added).

With an appropriate authorization seeking "any and all medical records," it would appear that a physician is required to release the entire stack of records, even those produced by other care providers. Not only is the term "medical records" defined broadly, the language of the patient's authorization that calls for the release of "any and all medical records" appears broad enough to encompass more than the provider's own generated records.

- N. Section 11: The MMRAA does not apply to copies of medical records provided to third party payers or insurers.

IV. RETENTION OF MEDICAL RECORDS

A. MEDICAL RECORDS

42 CFR '482.24(b)(1): Inpatient and outpatient records must be retained in their original or legally reproduced form for at least 5 years.

MCL '400.111b(8): Providers must retain records necessary to document fully the extent and cost of services, supplies or equipment provided to a medically indigent individual for 6 years after date of service.

B. HIPAA

1. Notice of Privacy Practices

HCPs generally must provide individuals with adequate notice of the uses and disclosures of PHI that may be used by the HCP, and the individual's rights and the HCP's legal duties with respect to PHI. These notices must be retained for at least 6 years from the date the notice was created or the date when it was last in effect, whichever is later. 45 CFR 164.520 and 45 CFR 164.530(i).

2. Policies and Procedures

HCPs must implement policies and procedures with respect to PHI that are designed to comply with the privacy regulations. These policies and procedures must be retained for at least 6 years from their date of creation or the date they are last in effect, whichever is later. 45 CFT 164.530(i)(l) and (j).

3. Consent Forms

Privacy regulations require certain entities to obtain an individual's consent prior to suing or disclosing PHI to carry out treatment, payment or health care operations. These consent forms must be retained for at least 6 years form the date the consent form was created or the date the consent form was last in effect, whichever is later.

4. Authorizations

HCPs generally may not use or disclose PHI without an authorization. Authorizations must be retained for at least 6 years from the date the authorization was created or the date when it was last in effect, whichever is later.

C. DESTRUCTION OF MEDICAL RECORDS

A common question often asked is how an HCP or facility should go about destroying medical records. There are a myriad of retention requirements pertaining to various type of medical records. Additionally, issues such as malpractice also dictate when medical records should be destroyed.

While the timing of destruction of medical records will vary from patient to patient, each HCP and facility generating medical records should have some written policy in place to address the retention and destruction of medical records. A good policy will include the following:

1. Consideration of both paper and electronic records. With the proliferation of electronic records, a document retention and destruction policy that focuses solely on paper records will be inadequate.
2. Consideration to how records are to be retained. This includes considering whether certain records need to be filed, organized, archived or maintained in a different manner from other records.
3. Consideration to how records are to be duplicated. An HCP or entity may require certain records to be maintained in duplicate (this may be due to the need for accessibility or the importance of the records).
4. Compliance with applicable retention laws. This requires looking at both state and federal law to see what applies, and then appropriately documenting compliance with them.
5. Establishment of procedures for disseminating records. This is critical in several respects. First, it simply may not be necessary for all employees to have access to all records. Second, it may have legal implications (for example under HIPAA's Privacy and Security Rules) if documents are accessed by those who have no legitimate reason to view such documents.
6. Development of programs to train employees about the record retention/destruction program so that it can be followed. Simply put, employees must know what to do with documents and management must regularly remind employees of how the policy works.
7. Designation of personnel to oversee the program.
8. Accountability for following the program. This entails providing a system for discipline in the event an employee fails to abide by the program.

9. Use of appropriate technological consultants. Any procedures for handling electronic documents, e-mail, rotation of back-up tapes and other issues raised by storage and use of electronic records should be “blessed” as reasonable.
10. Retention of all documentation relating to the development and implementation of the policy.
11. Development of the appropriate policy to notify patients of the destruction of records.
12. Development of a reliable mechanism that enables the company to suspend the destruction of documents upon notice of potential litigation, receipt of subpoenas, or an existing or potential government inquiry

The program that is developed should be placed in writing, not only to provide written guidance to personnel but also to substantiate the existence of the program to appropriate regulatory bodies.

V. SUBPEONAS

How does a Health Care Provider (“HCP”) respond to a subpoena?

An HCP receiving a subpoena should determine whether a request for records constitutes an “order of a court or administrative tribunal” or a subpoena or discovery request, because the standards for HIPAA compliance are significantly different for these two types of requests.

HIPAA allows an HCP to disclose PHI in the course of any judicial or administrative proceeding “in response to an order of a court or administrative tribunal, provided that the Covered Entity discloses only the protected health information expressly authorized by such order.”

An HCP that receives a court order signed by a judge that directs it to release an individual’s medical information, the HCP may do so without patient authorization.

The HCP may disclose only the PHI that is expressly authorized in the court order and not more. If the HCP does not comply with the court order, it risks being held in contempt of court.

The Privacy Rule permits an HCP to disclose PHI “in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal,” but only if the following requirements are met:

- A. The HCP receives satisfactory written assurance from the party seeking the information (the Requestor) that reasonable efforts have been made by the Requestor to ensure that the patient has been given notice of the request.
- B. The HCP receives satisfactory written assurance from the Requestor that reasonable efforts have been made by the Requestor to secure a qualified protective order.

If you have any questions about the issues raised in these materials, please contact Mr. Christopherson at Christopherson@ddc-law.com or 231-929-0500.

The opinions expressed in these materials are intended for general guidance only. They are not intended as recommendations for specific situations. The laws, rules, regulations and statutes are subject to change. As always, please consult a qualified attorney for specific legal guidance.

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