The Medical Record, Documentation, and Filing

- A quick easy breakdown for MA students

The Medical Record includes/must be:

1. Complete and accurate
2. Demographics
3. Charting

HIPAA and the medical record

1. Record management
2. Privacy officer
3. Security rule

- Ensure confidentiality, integrity, and availability
- Have policies and procedures in place that identify and protect reasonably anticipated threats to the security or integrity of the information
- Have policies and procedures in place to protect against anticipated, impermissible uses or disclosures
- Ensure compliance with the Security Rule and their workforce

EHR advantages:

1. Searchable
2. Quick lab and imaging results
3. Electronic prescriptions
4. Reminders
5. Coordinating care between providers
6. Access to previous chart notes
7. Voice recognition software for dictation
8. Streamline billing and coding
9. Picture of pt
10. Trending health data

Parts of the medical record:

- Pt info and demographics
- Administrative data
- Financial and insurance info
- Correspondence
- orders/referrals
- Past medical records
- Clinical data
- Progress notes
- Imaging
- Labs
- medications/ allergies

Progress notes should be:

- Chronological

- Inside and outside the practice
- CC
- History
- Remedies
- Update
- Pain, 0-10

Acronyms for progress notes:

SAMPLE

- S/S
- Allergies
- Medications
- Past medical history
- Last oral intake
- Events leading up to current CC

OPQRST

- Onset
- Provocation
- Quality
- Radiation
- Severity
- Timing

Steps in filing:

1. Inspecting
2. Indexing
3. Coding
4. Sorting
5. Storing
6.

Types of filing:

1) Alphabetical
2) Numerical
3) Subject
4) Geographic
5) Chronological
6) Color coding

Summary

- Medical records serve multiple purposes: continuity of medical care between providers; documentation to verify necessity of procedures for insurance reimbursement; chronological record of events on which to build subsequent care
- HIPAA protections in place are designed to maintain the security of pt information while enabling providers to share critical info about pts
- HIPAA Privacy Rule provides standards for patients confidential, personal information
- HIPAA Security Rule applies to paper records but is mostly for electronic info and methods to protect it
- The provider and the hospital have the right to restrict the record to their premises. The pt has a right to expect that privacy
- Although a physician is allowed to sever or terminate the pt/physician relationship, in order to avoid allegations, the physician needs to notify the pt in writing
- Financial and insurance info should be guarded carefully. This includes insurance policy #'s, credit card info, any legal documents, etc

- Progress notes are entered chronologically
- Problem-oriented medical records (POMR) are organized and entered based on where they came from. The POMR begins with the standard database info, including partner profile, CC, ROS, CPE, and lab reports
- The “steps” in filing include (1) inspecting (2) indexing (3) coding (4) sorting (5) storing
- HIPAA requires all medical records, signed consent forms, authorization forms, any other related docs to be retained for 6 yrs. Records of dead people must be maintained for 2 yrs