



**EFFECTIVE DATE:** 11 | 15 | 2011

**POLICY LAST UPDATED:** 06 | 05 | 2018

### OVERVIEW

The purpose of this policy is to establish at a minimum medical record standards to facilitate communication, coordination and continuity of care; to promote efficient and effective treatment; and to ensure the accurate documentation of services rendered, in order to effectuate correct coding and reimbursement of services. This policy is developed in accordance with state, federal and CMS guidelines and requirements.

### MEDICAL CRITERIA

Not applicable.

### PRIOR AUTHORIZATION

Not applicable.

### POLICY STATEMENT

1. Maintenance of the Medical Record
  - a. A medical record shall be maintained for every individual who is evaluated or treated in a hospital, clinic, or physician's office.
  - b. The medical record may consist of both electronic and paper documentation.
2. Confidentiality
  - c. The medical record is confidential and is protected from unauthorized disclosure by law.
3. Content
  - d. Medical record content shall meet all State and federal legal, regulatory and accreditation requirements including the Medicare Conditions of Participation 42 CFR Section 482.24. (Appendix A contains a listing of required medical record documentation content, and current electronic or paper format status.)

For instance:

1. 482.24(c)(1) - All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
  2. 482.24(c)(1)(i) - All orders, must be dated, timed, and authenticated promptly by the ordering practitioner.
  3. 482.24(c)(1)(iii) - All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific time frame for the authentication of verbal orders, verbal orders must be authenticated within 48 hours
- a. All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers. With these criteria in mind, an individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard.
  - b. All documentation and entries in the medical record, both paper and electronic, must be identified with the patient's full name and a unique medical record number.

4. Completion, Timeliness and Authentication of Medical Records
  - a. All medical record entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in the medical record in advance of the service provided to the patient.
  - b. Every medical record must be complete with all documentation of orders, diagnosis, evaluations, consultations, medications, treatments, test results, care plans, discharge plans, consents, interventions, discharge summary, and care provided along with the patient's response to those treatments, interventions, and care. The record must be completed promptly after discharge in accordance with State law and/or hospital policy but no later than 30 days after discharge.
  - c. All operative and procedure reports must be completed immediately after surgery.
  - d. All medical record entries must contain date and time of entry.
  
5. Form and Retention of Medical Records
  - a. Medical records must be retained in their original or legally reproduced form for a period of at least 10 years.
  - b. The provider must have a system of coding and indexing medical records. There must be a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.
  - c. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate.
  
6. Maintenance and Legibility of Record
  - a. All medical records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record.
  - b. All entries in the medical record must be legible to individuals other than the author.
  
7. Corrections and Amendments to Records
  - a. When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.
  - b. The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of medical records must not otherwise be edited, altered, or removed.
  - c. Documents created in a paper format:
    - a. Do not place labels over the entries for correction of information.
    - b. If information in a paper record must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and signature of the person making the revision.
    - c. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above in (2), and rescanning the document.
  - d. Documents that are created electronically must be corrected by adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.
  - e. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:
  - f. Identify the new entry as a "late entry"
    - a. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.

- b. Identify or refer to the date and circumstance for which the late entry or addendum is written.
- g. When making a late entry, document as soon as possible.

Note: Changes to medical records will not be accepted for reimbursement changes when in response to a medical record audit.

#### **COVERAGE**

Not applicable.

#### **BACKGROUND**

Not applicable.

#### **CODING**

Not applicable.

#### **RELATED POLICIES**

None

#### **PUBLISHED**

Provider Update, August 2018

Provider Update, Dec 2011

#### **REFERENCES**

Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164.

Medicare Conditions of Participation, 42 CFR Section 482.24

<https://www.cms.gov/transmittals/downloads/R47SOMA.pdf>

<https://www.cms.gov/transmittals/downloads/R37SOMA.pdf>

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