Records Management 101

Essential components all staff need to know

PRESENTER:
JOAN L. USHER, BS, RHIA, ACE
AHIMA Approved ICD-10-CM Trainer
JLU HEALTH RECORD SYSTEMS
TEL: (781) 829-9632 FAX: (781) 829-9636
www.jluhealth.com

Learning Objectives

- Understand when to properly complete documentation elements
- Determine what is essential to the maintenance of the legal health record
- Review the correct retention for scanned & permanent documents

Legal Components

Legal Medical Record

- The record contains the information needed to support the patient's diagnosis and condition
  - Evidence of what occurred in the care of the patient and justifies treatment & services provided
- Legible
- Appropriate Authentication (Credential, Signed & Dated)
- Clear & concise language

Not Part of Legal Medical Record

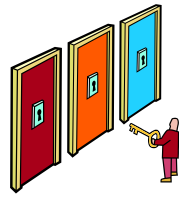
- Alerts, reminders, pop-ups
- Continuing care records from another healthcare provider unless a medical decision was based on the information
  - Example: hospital discharge summary, physician visit note
- Physician Attestation for legibility
- Audit Trails

Contents of Legal Record

- Admission Packet Forms
- Consents
- HIPAA Notice Privacy Practice
- Legal notices
- Face to Face Documentation
- Physician orders
- Clinical Documentation

Records need to be checked for …

- Timeliness
- Completeness
- Accuracy



Timeliness

- Regulation for F2F
  - 90 days before – 30 days after
- Referral
  - 48 hours from date of referral to visit patient
- Verbal order to start care
  - Documented on plan of care
- Home Health Certification & POC (485)
  - To be signed timely
  - Dated by MD

Completeness

- QA the admission packet for completeness of documents, signatures & date
- QA the F2F documentation for all essential elements
- Review the OASIS for M questions conflicts
- Enough documentation to support POC

Accuracy

- Documenting at “point of care”
- Documentation of facts
  - Objective & Measurable
  - Justification of Medical Necessity
- Be careful of spelling
- Individualized to the patient

Standardized Records

- Standardized MR entries can create problems when used improperly.
  - Standardized entries are statements that describe usually routine care.
- Clinicians may select a standardized entry from a menu in an EHR software program.
- Paper documents use check off boxes.
- Use of these entries saves time but if clinician selects the wrong entry or does not confirm the language of the entry is appropriate for the patient, an inaccurate or incomplete record may result.

Drop Down Menus

- Drop down menus may be considered standardized not customized when documentation does not change from visit to visit

- Condition: Client condition is_____
  - Unchanged
- POC: Client is_____
  - Partially participating in POC
  - Up as tolerated, no activity restrictions
- Homebound:
  - Max assist; Adult Day Health
- Teach: Topic # Who - How - Response
  - Medications Pt Verbal Verbalized understanding

"Cloned" Documentation

- Documentation is considered cloned when it is worded exactly like or similar to previous entries
  - Also when the documentation is exactly the same from patient to patient
    - Cut & paste functionality
  - Individualized patient notes for each patient visit are required
  - Documentation must reflect the individual patient's condition necessitating treatment, the treatment rendered and the overall progress of the patient to demonstrate medical necessity

Physician Signatures

- Scanned
- Faxed
- E-signature
- Legibility
- Dated by the Physician
  - 42CFR 424.22 (D) 2 "The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan".

Complying with Medicare Signature Requirements

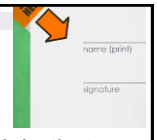
- For a signature to be valid, the following criteria must be met:
  - Services that are provided or ordered must be authenticated by the ordering practitioner;
  - Signatures are handwritten or electronic (stamped signatures are not acceptable); and
  - Signatures are legible.
  - Acceptable to submit signature log or attestation statement
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Legibility

- From ADR request: *If you que legibility of the provider signature, you should submit an attestation statement*
- Options:
  - Obtain signature when new provider referral
  - Obtain signature at time of request
- Illegibility can result in denial for services

Consent

Consent to Treat



- Consent to treatment is the principle that a person must give their permission before they receive any type of medical treatment or examination.
- The clinician explains to the patient BEFORE any hands on care is provided.
- Consent is required from all patients regardless of the intervention.

Validity

- For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.
- Definitions:
  - Voluntary – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from agency or family.
  - Informed – the person must be given all of the information in terms of what the treatment plan involves.
  - Capacity – the person must be capable of giving consent, which means understanding the information given to them, and being able to use this information to make an informed decision.

Giving Consent

- For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.
- Signed and dated by the patient
- If patient unable to sign
  - Physical impairment
    - "x" is sufficient with agency witness
  - Mental Impairment
    - Guardianship, Advanced Directive, Health Care Proxy
    - Dilemma when patient is incompetent but no personal representative

Capacity

- A person lacks capacity if their mind is impaired or disturbed in some way, and person is unable to make a decision at that time.
- Examples:
  - Behavioral health conditions – such as schizophrenia or bipolar disorder
  - Alzheimer's disease/dementia
  - Severe learning disabilities
  - Brain damage – from a CVA or other brain injury

Point of Care

Timely Documentation

- Documentation should be completed at or as close to Point of Care as possible
  - In the Home
  - In the Car
- *Tip: Completing the documentation in the patient's home allows for the most comprehensive note that encompasses what was seen, heard and done for the visit*

Advantages POC Documentation

- Improves workflow
  - Completion at time of visit
- Improves patient safety
  - Accuracy of documentation
- Promotes collaboration & improves communication
  - Timeliness of documentation

Plan of Care/F2F

Plan of Care

Purpose of a plan of care is to guide all those who are involved with the patient to provide appropriate treatment & interventions to ensure the best outcome for the patient.

- Provides a "Road Map" to guide clinicians
- Standardized clinical process for identified diagnosis relevant to a specific patient

Accuracy & Completeness

- The Plan of Care accurately represents the patient's needs in consideration of the
  - condition of the patient,
  - complexity of the service, and
  - accepted Standards of Practice
- Orders include the discipline, frequency, duration, and treatment to be provided

Steps in POC Process

- Review diagnoses listed on F2F and referral documents
- Carry over diagnostic information to physician order (485) relevant to the services rendered in the home
- The F2F encounter diagnoses need to be reflected in the POC

Deficiency G158

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

- This deficiency could include the initial plan of care, recertification plan of care and changes to the plan of care by interim physician order.

Problems Identified G158

- Visits for all disciplines not made at the frequency ordered on the plan of care
- No explanation for missed visits
- No documentation physician notified of missed visits and reason
- Lack of compliance with physician orders for assessment and teaching related to diabetic assessment and management, pain assessment and management, and wound assessment and care
- Lack compliance with other skilled assessment and teaching ordered by the physician
- Lack of orders for specific modalities such as heat, cold, ultrasound, electrical muscle stimulation, etc.
- Therapy orders stated as goals rather than specific procedures and modalities
- Lack of orders for changes in medications or treatments
- Lack of complete resumption of care orders post-hospitalization

Deficiency G159

The plan of care developed in consultation with agency staff covers all pertinent diagnosis, including mental status, types of service and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

Problem Identified G159

Problems identified during home visits and clinical record review related to G159 includes:

- Areas of the 485 or other plan of care document are left blank
- Incomplete list of medications including OTC drugs when compared to the comprehensive assessment and medication record. May be incomplete for drug, dosage, frequency, and/or route of administration
- Orders for therapy or social work evaluations obtained during referral or the initial visit are not included on the plan of care
- Incomplete physician orders for wound care, IV dressings, flush solutions, sliding scale insulin, frequency of blood sugar checks to be performed by patient, nutritional requirements, and functional limitations
- The goals were not measurable or specific to problems identified during the comprehensive assessment
- The Plan of Care, either initial or recertification, was not developed and sent to the physician for review and signature in a timely manner, according to agency policy

Corresponding with Office

About Patients

Providing Protected Health Information (PHI)

Secure Messaging

Acceptable

- Within the EHR software
- Individual Voice mail

Unacceptable

- Through Outlook
- Global voicemail
  - Minimum necessary standard
- Global distribution of on call report

General Release of Information

Release of Information

- Written authorization required
- Except in circumstances of treatment, payment or healthcare operations
- Need to know
- Telephone release of information
  - Medical emergencies
  - To perfect a medical benefit or claim

Components to Proper Authorization

1. Written Authorization
2. Patient's Name, Address And Date Of Birth
3. Designate To Whom The Information Is To Be Given And For What Purpose
4. It Must Be Signed And Dated
5. Reasonable Period Of Time
6. Expiration/Revocation Statement
7. Signature Verified
8. Informed Consent, If Applicable
9. Facsimile Statement, If Applicable
10. Re-disclosure Policy

Sensitive Information

1. AIDS/HIV Testing
2. Drug Dependency, addiction or abuse
3. Alcohol abuse/alcohol tests
4. Mental illness or retardation
5. Communications to social workers, psychotherapists, psychologists
6. Counselors, or other mental health advisors
7. Venereal disease/STD
8. Sexual assaults
9. Domestic violence
10. Illegitimacy of birth, Paternity
11. Abortion
12. Other information embarrassing or damaging to a resident

Charging for Copies HIPAA

- *May a covered entity charge individuals a fee for providing the individuals with a copy of their PHI?*
- The fee may include only the cost of certain labor, supplies, and postage.
- http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html#newlyreleasedfaqs

Charging for Copies

- MA Effective October 1, 2016, the maximum rate that providers may consider using in developing the rate for medical record copies is as follows:

a. $21.84 base charge for clerical and other administrative expenses related to complying with the request for making a copy of the record;
   - Base fee waived for a record required for claims adjudication, eligibility, administrative reviews

b. $0.74 per-page charge for the first 100 pages copied; and

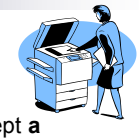
c. $0.38 per-page charge for each page in excess of 100 pages.

Record Retention

Retention

- Home Health agencies
  - Five years after the month the cost report to which the records apply is filed with the intermediary, unless state law stipulates a longer period of time.
  - 42 CFR 484.48(a)
- Hospice care
  - 42 CFR 418.74
  - All records shall be maintained for a period of seven years after death or discharge.
  - 105 CMR 141.209

Scanning



- Original paper records should be kept **a minimum of thirty to ninety days after scanning is complete** for any omissions or quality concerns.
  - No regulatory requirement for the # of days unless state law
- This time period is to allow for any errors to be detected and for re-scanning if necessary.

Policies for Retention/Security

- The HIPAA Security Rule requires that covered entities implement policies and procedures to address the final disposition of electronic PHI and/or the hardware or electronic media on which it is stored.

Disposing of PHI Correctly

- Paper records
  - shredding, burning, pulping, or pulverizing the records so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed.
- Electronic record
  - clearing
    - Overwrite media using software or hardware products
  - purging
    - Exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains
  - destroying the media
    - disintegration, pulverization, melting, incinerating, or shredding

Consequences

- **HIPAA Fines Total $140K Against Billing Firm, Pathology Practices**
- Four pathology practices in Massachusetts and owners of a former billing firm have been fined a total of $140,000 by the State of Massachusetts after medical and billing records were disposed of at a recycling station.

Successful Record Management

- Understand the components of the record
- Check documentation for timeliness, completion and accuracy
- Keep PHI confidential and secure

Resources

- Federal Trade Commission http://www.cintas.com/pdf/Document-Management/FTC-Privacy.pdf
- DHHS FAQs Frequently Asked Questions About the Disposal of Protected Health Information http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/disposalfaqs.pdf
- A Guide to the Massachusetts Public Records Law http://www.sec.state.ma.us/pre/prepdf/guide.pdf
- MA Records Management Unit http://www.sec.state.ma.us/arc/arcrmu/rmuidx.htm
- Massachusetts Statewide Records Retention Schedule http://www.sec.state.ma.us/arc/arcpdf/0211.pdf
- MA Electronic Records Management Guidelines http://www.sec.state.ma.us/arc/arcpdf/Electronic_Records_Guidelines.pdf

ABOUT THE SPEAKER:

JOAN L. USHER, BS, RHIA, ACE, President, JLU Health Record Systems, Pembroke, MA

- Degrees & Certifications
  - Degree in Health Information Management (HIM)
  - Certified OASIS and Coding Specialist for over 9 years
  - AHIMA Approved ICD-10-CM Trainer
- Affiliations
  - Massachusetts Health Information Management Association (MaHIMA), BOD 2004-2011, President 2005, member since 1984
  - American Health Information Management Association (AHIMA) delegate 2002-2006, member since 1984
  - Member, Long Term and Post Acute Care Committee (LTPAC) of American Health Information Management Association (AHIMA), 2013-2015
  - Home Care Alliance of MA, Board of Directors, 2012-2017 Foundation Home & Health MA, member QI Committee
  - Hospice & Palliative Care Federation MA, Board of Director 2008-2016
- Pertinent Publications
  - MaHIMA, Medicio- Legal Guide to Health Record Information, © 2016 contributing author, © 2004 editor, www.mahima.com
  - Author, Rapid Reference Coding Guide, 2016 edition, www.jluhealth.com © 2016
  - Homecare DIRECTION, monthly coding column and contributing author www.hcpro.com