TO PRODUCE OR NOT TO PRODUCE???

NOW THAT IS "THE" QUESTION!

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If you have the right foundation in place the decision is easy.

What foundation you might ask…….

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SOMETHING AS SIMPLE AS HAVING POLICIES AND PROCEDURES THAT ADDRESS

- COMPLETE DOCUMENTATION
- THE MEDICAL RECORD
- DOCUMENT RETENTION
- DOCUMENT PRODUCTION

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24 HOUR CHART CHECK POLICY

PHYSICIAN ORDERS

- INTERDISCIPLINARY NOTES
- CARE PLAN UPDATES

COMPLETION OF CHART ENTRIES

- ALL SHIFT NURSING NOTES
- CARE PLAN UPDATES
- ASSESSMENTS

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DOCUMENTATION:

Creates a record of what was done;

Communication to members of the multi-disciplinary team;

Establishes care is appropriate; and

Tracks progress of care or lack thereof.

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Documentation

An up hill battle!!!

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The only surprise when reviewing documentation is when it is complete….therefore there are really no surprises….

Blanks

Inaccurate

Incomplete

Inconsistent

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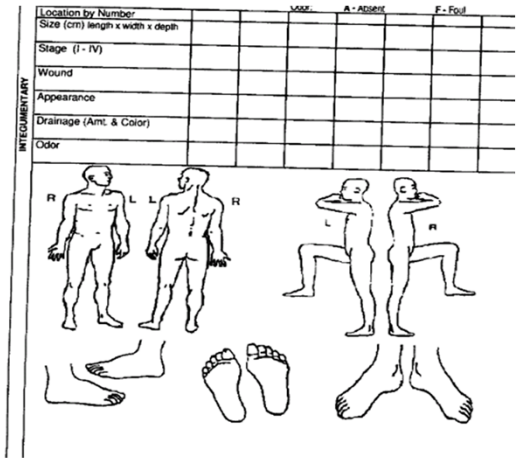

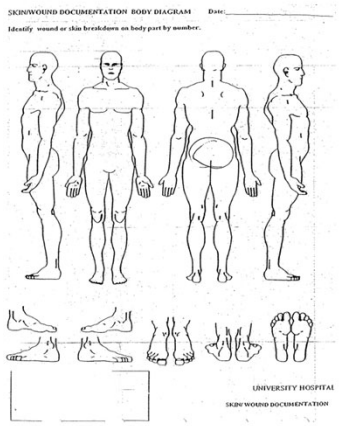

ANYTHING MISSING?

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Far too often the blanks, incompleteness, inaccuracies and inconsistencies prohibit us from putting forth a full, complete and verifiable defense when patients claim they developed a pressure ulcer because they were not assessed properly!

This is true regardless of the fact that the care and treatment was appropriate, timely, and within the standard of care. Even when the pressure ulcer was medically unavoidable!

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EXAMPLES OF DOCUMENTATION ISSUES

CONFLICTING DOCUMENTATION

- Fall assessment on admission reflects resident had a fall within one month prior to admission.
- Comprehensive care plan did not include fall preventions until two months after admission.
- MDS Form reflects no history of falls.
- Annual Survey: F 0656 SS=D and F 0641 SS=D

IMPACT ON SUBSEQUENT LITIGATION

- Failure to conform all sections of a resident's chart provides fuel for a resident and/or his/her family to claim that the care provided was insufficient as borne out by the records.
- While defense counsel will aggressively object to the use of the Annual Survey Citation by Plaintiff's counsel to prove negligence, the Court's have not been consistent in rulings on this issue.

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RESULT

Facility ends up paying out on a case that might otherwise have been successfully defended…

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The Facts and Just the Facts

- Never
  - Assume
  - Editorialize
  - Use the chart for personal satisfaction
- If you do any of these things then the risk of payment on the claim dramatically increases.

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THE MEDICAL RECORD

THERE TWO SETS OF RECORDS

LEGAL HEALTH RECORD

DESIGNATED RECORD SET

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IS THERE A DIFFERENCE BETWEEN THE DESIGNATED RECORD SET AND THE LEGAL HEALTH RECORD?

But of course there is…….

You did not expect this to be that easy did you?

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Designated Record Set

- A group of records maintained by or for a covered entity that is the medical and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; information used in whole or in part by or for the HIPAA covered entity to make decisions about individuals.

Legal Health Record

- The business record generated at or for a healthcare organization. It is the record that would be released upon receipt of a request. The legal health record is the officially declared record of healthcare services provided to an individual delivered by a provider.

AHIMA. "Fundamentals of the Legal Health Record and Designated Record Set." Journal of AHIMA 82, no.2 (February 2011): expanded online version.

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Contents of the Designated Record Set

- Must be defined in the organizations policy and required by the HIPAA privacy rule.
- The content of the designated record set includes medical and billing records of covered providers; enrollment, payment, claims, and case information of a health plan; and information used in whole or in part by or for the covered entity to make decisions about individuals.

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Content of the Legal Health Record

- Should be defined in the organization's policy and can include individually identifiable data in any form—paper or electronic—which is directly used in documenting services provided and the resident's health status.
- It excludes administrative, derived, and aggregate data.

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Both Sets of Records Should Contain

Admission assessment

Orders

Interdisciplinary progress notes

Lab reports

Physician progress notes

Pharmacy records

Vital signs

Assessments

Consults

MAR and TAR

Comprehensive Care Plan

Outside provider records—
i.e. ophthalmology, cardiology, hospitals

Personal health records

Patient generated records

Authorizations and consents

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Clinical records - 28 Pa. Code § 211.5
Long term care facility's clinical records must conform to the following requirements:

- -Information contained in the resident's record is privileged and confidential;
- -Release of information from the resident's record is prohibited except in the following circumstances:
  - -To representatives of the department of aging ombudsman program;
  - -On the written consent of the resident or his designated agent; and
  - -To authorized representatives of the state and federal government conducting their official duties.
- -Records must be *retained for seven years* following a resident's discharge or death; and
- -**Records must include the following information**:
  - -**Physician's orders, observation and progress notes, nurses' notes, medical and nursing history and physical examination reports;**
  - -**Identification information, admission data, a resident needs assessment, appropriate treatment plan and plan of care and services; and**

Hospital diagnoses authentication, diagnostic and therapeutic orders, reports of treatment, clinical findings, medication records and discharge summary.

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Do Not Omit Communications Related to Resident Care

All forms of communications between healthcare providers relating to resident care decisions must be retained and included in both sets of records. That includes emails!

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Designated Record Set only

Committee Reports of patient specific care decisions;

Note: Other legal privileges may well apply to these records.

Billing records;

Payment and claims records;

Health plan enrollment records;

Case management records; and

Other records used to make decisions about individuals.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NEITHER RECORD SET SHOULD INCLUDE

- QUALITY IMPROVEMENT REPORTS AND QUALITY ASSURANCE REPORTS AND OR ABSTRACTS, PEER REVIEW, PERFORMANCE EVALUATIONS
- STATISTICAL DATA, BUSINESS PLANNING
- COMMITTEE MINUTES THAT ARE NOT RESIDENT SPECIFIC TREATMENT RELATED
- PSYCHCOTHERAPY NOTES
- INFORMATION COMPILED IN REASONABLE ANTICIPATION OF A LEGAL PROCEEDING

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HOW LONG DO WE NEED TO RETAIN THE RESIDENT'S MEDICAL RECORD?

Each state has its own set of regulations which dictate how long a healthcare provider must retain medical records.

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State	Statute	Retention Period
Alabama	Ala. Code § 22-21-8	5 years
Alaska	12 AAC 02.010	10 years
Arizona	Ariz. Rev. Stat. § 12-2297	7 years
Arkansas	Ark. Code Ann. § 5-37-204	5 years
California	Cal. Code Regs. tit. 16, § 1367.6	7 years
Colorado	Colo. Rev. Stat. § 25-1-802	10 years
Connecticut	Conn. Gen. Stat. § 52-146d	7 years
Delaware	16 Del. Admin. Code § 4463	7 years
District of Columbia	D.C. Mun. Regs. tit. 22, § 401	7 years
Florida	Fla. Stat. § 456.057	5 years
Georgia	Ga. Comp. R. & Regs. r. 111-8-24-.04	10 years
Hawaii	Haw. Admin. R. § 16-89-78	7 years
Idaho	Idaho Admin. Code r. 16.03.04.251	7 years
Illinois	77 Ill. Admin. Code § 250.520	10 years
Indiana	Ind. Code § 16-39-6-8	7 years

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Iowa	Iowa Admin. Code r. 641-34.9(147,148)	10 years
Kansas	Kan. Admin. Regs. § 28-1-6	10 years
Kentucky	Ky. Rev. Stat. Ann. § 344.040	5 years
Louisiana	La. Admin. Code tit. 46, pt. LXVII, § 1653	10 years
Maine	Me. Code R. tit. 10, § 2195	7 years
Maryland	Md. Code Regs. 10.32.03.05	5 years
Massachusetts	243 Mass. Code Regs. § 2.07	7 years
Michigan	Mich. Comp. Laws § 333.16213	7 years
Minnesota	Minn. Stat. § 147.091	7 years
Mississippi	Miss. Admin. Code § 15-16-7	7 years
Missouri	Mo. Code Regs. Ann. tit. 19, § 30-20.050	10 years

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Montana	Mont. Code Ann. § 37-2-305	10 years
Nevada	Nev. Rev. Stat. § 629.061	5 years
New Hampshire	N.H. Code Admin. R. Ann. He-P 803.03	10 years
New Jersey	N.J. Admin. Code § 13:35-6.6	7 years
New Mexico	N.M. Admin. Code § 16.10.10.8	10 years
New York	N.Y. Pub. Health Law § 18	6 years
North Carolina	N.C. Gen. Stat. § 90-411	11 years
North Dakota	N.D. Admin. Code § 61-02-05-04	10 years
Ohio	Ohio Admin. Code § 4731-27-06	7 years
Oklahoma	310 Okla. Admin. Code § 675:10-7-4	7 years
Oregon	Or. Admin. R. 333-535-0060	10 years
Pennsylvania	28 Pa. Code § 115.23	7 years

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Rhode Island	R.I. Gen. Laws § 5-37-5	10 years
South Carolina	S.C. Code Ann. Regs. § 61-7	10 years
South Dakota	S.D. Codified Laws § 36-4-19	7 years
Tennessee	Tenn. Comp. R. & Regs. 0880-2-.19(6)	10 years
Texas	Tex. Occ. Code § 159.002	7 years
Utah	Utah Admin. Code r. 156-37-302	7 years
Vermont	Vt. Code R. 16-1-003:3	10 years
Virginia	Va. Code Regs. § 18VAC85-21-250	5 years
Washington	Wash. Admin. Code § 246-08-400	6 years
West Virginia	W. Va. Code R. § 16-1-9	10 years
Wisconsin	Wis. Admin. Code DHS § 92.05(1)	7 years
Wyoming	Wyo. Code R. § 7-3-3	10 years

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DOCUMENT PRODUCTION

- Resident
- Family
- Third party

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PATIENT/RESIDENT'S RIGHT TO ACCESS

- HIPAA
  - 30 days to produce
- STATE
  - Varies State to State.
  - States regulations that do not address timeliness of production or have longer time limits are pre-empted by HIPPA.

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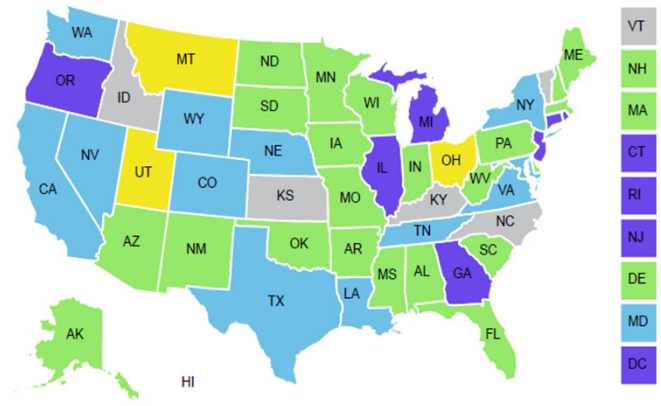

Click on a state to see more information on ***Medical Records Collection, Retention, and Access*** *in that state*

State Medical Record Access Requirements Compared to HIPAA

Stronger than HIPAA Same as HIPAA Preempted by HIPAA

No law specifically granting individual access right; HIPAA applies

HIPAA applies to covered entities, and state has additional requirements for entities not covered by HIPAA

Stronger than HIPAA; Same as HIPAA; Preempted by HIPAA; No law specifically granting individual access right—HIPAA applies; HIPAA applies to covered entities and state has additional requirements for non covered entities

Health Information & the Law, Milken Institute School of Public Health The George Washington University

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INDIVIDUAL REQUEST FOR PERSONAL MEDICAL RECORDS

- Organization should have written policy regarding the requirements for providing resident's access to their medical records.
  - Policy should include the specific form which the resident can complete to obtain a copy of their records.
    - Ideally the form should list the various parts of Designated Record Set to permit the resident to identify the specific portions of the record desired.

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FAMILY MEMBER REQUEST FOR RECORDS

- The organization should include on its policy for access to residents' records the requirements necessary for release of the records to a family member.

- Generally, a patient authorization is required for external disclosure of PHI to someone other than the patient or the patient's personal representative.

  A personal representative is a person authorized to act on behalf of an individual in making health care related decisions and is treated under HIPAA as if that person was the individual.

45 CFR Part 160 and Subparts A and E of Part 164

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In the case of a deceased resident's medical records, the executor or administrator of the decedent's estate is to be treated as the decedent's personal representative.

-An executor is the individual named by the decedent in his/her/their will to administer the decedent's estate. *Request a copy of the Short Certificate*

-An administrator is the individual appointed by the court to administer the decedent's estate if the decedent died without a will. *Request a copy of the Short Certificate*.

-HIPPA also permits the disclosure of a decedent's PHI to family members or other persons involved in the health care or payment of care for the decedent prior to death.

45 CFR Part 160 and Subparts A and E of Part 164

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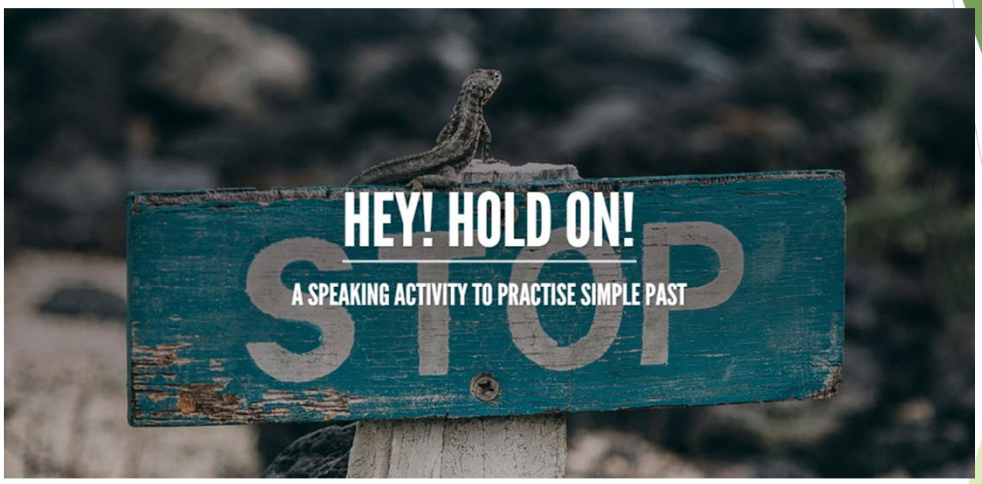

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LITIGATION HOLD

Upon receipt of a letter of representation with or without a request for the medical record and with or with the demand to put a litigation hold on the chart---

The first thing that must be done is to place a LITIGATION HOLD ON THE DESIGNATED RECORD SET INCLIUDING THE MEDICAL CHART.

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THIRD PARTY ACCESS TO A RESIDENT'S MEDICAL RECORDS

- WHO
  - Who is making the request?
- WHY
  - Why is the request being made?
- HOW
  - How is the request being made?
- WHAT
  - What do we do in response to the request?

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PRE-LITIGATION REQUESTS

- Attorney for resident sends a letter of representation and requests a copy of the resident's medical chart.
  - Make sure the letter is accompanied by a signed valid authorization.
  - Make sure to put a **litigation hold** on the Designated Record Set and the Legal Health Record.
  - Respond to the request in accordance with your state's regulations.
  - Be mindful that at times the authorization is not for the entire Designated Record Set. Only produce that which is requested in the authorization.

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COURT ISSUED SUBPOENA FOR RECORDS

- Not the same as a request for records directly from the resident or resident representative.
  - Multiple reasons why a third party might want a copy of the records
    - Resident may have unrelated litigation and is claiming injury resulted in admission to organization.
    - Resident may have unrelated litigation the post dates the admission to your organization and the third party wants the records for damages defense.

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- Timing and scope of response is dictated in the terms of the subpoena
  - Could demand records within 20 days, 30 days, or longer
  - Could limit the request for records during a specific time period—within the last 3, 5, or 10 years…
  - Could identify the specific records being requested—physical therapy records; or the entire chart.

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ALWAYS REQUEST A HIPAA COMPLIANT AUTHORIZATION SIGNED BY THE RESIDENT OR PERSONAL REPRESENTATIVE OF THE RESIDENT BEFORE PROVIDING INFORMATION SOUGHT.

If desired, organization can supply the authorization form to be completed by the entity/individual requesting the records.

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NOTICE OF REQUEST TO PRODUCE DOCUMENTS/THINGS IN LITIGATION

Plaintiff's generally request tons of information in discovery. Your counsel will determine what constitutes a legitimate request. However, when the request is for a complete copy of the resident's chart/medical record it is most helpful to the defense to give your attorney all parts of the medical record.

The organization is in the best position to know what the medical record should contain. Failing, even unintentionally, to provide counsel with the complete record can turn a defensible case into a nightmare all because the complete record was not provided.

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IS

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- In addition to having **a policy** which defines what constitutes the medical record, **another key element** for the production of a complete medical record is to **designate and train an individual who will be responsible for compiling the medical record** in response to requests by:
  - A resident
  - A personal representative of a resident
  - An attorney seeking records pre suit
  - A subpoena issued by a court
  - A party through a legitimate document request in discovery

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OUR GOAL TODAY IS TO AVOID THE FOLLOWING TYPES OF "OH WOE IS ME" CASES!

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Roseann is a 1983 graduate of Temple University School of Law, with an undergraduate degree from LaSalle University in 1980. Roseann is a shareholder and co-managing partner of Goldfein and Joseph. Roseann joined Goldfein and Joseph in 1985.

Roseann concentrates her civil litigation practice in the defense of medical malpractice claims, long term care, continuing care communities, personal care and assisted living communities, insurance casualty claims as well as insurance coverage and licensing issues.

Roseann has presented multiple Continuing Medical Education courses and seminars to healthcare providers on issues related to litigation including but not limited to: documentation, depositions, apology statutes, violence in the work place, data breaches and wounds. Roseann has also been an instructor of a trial advocacy course at Penn State Dickinson School of Law.

Roseann served as a member of the Board of Directors for St. Catherine LaBoure Medical Clinic, a non profit organization that provided healthcare for the uninsured. Roseann is a member of many professional organizations such as RIMS, ASHRM, DRI, PLDF and PDI.

Roseann is admitted to practice in Pennsylvania, New Jersey and in the United States District Court for the Eastern District of Pennsylvania, the United States District Court of New Jersey, and the United States Third Circuit Court of Appeals.

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