TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
EL PASO

Ambulatory Clinic Policy and Procedure

Title: **MANAGEMENT OF MEDICAL RECORDS**	Policy Number: **EP 5.1**
Regulation Reference: Joint Commission	Effective Date: **5/2015**

Policy Statement:

It is the policy of the Texas Tech University Health Sciences Center at El Paso (TTUHSC at El Paso) Ambulatory Clinics to express in writing its policy on medical record documentation of patient care.

Scope and Distribution:

This policy applies and will be distributed to all TTUHSC at El Paso Ambulatory Clinics.

Procedure:

1. The patient's clinic medical record shall be completed and signed legibly in blue or black ink or electronically in the Electronic Medical Record (EMR) by those practitioners involved in the patient's care each visit.

2. Teaching Physician documentation shall reflect appropriate presence and participation for each visit when resident staff is involved in the patient's care. The paper record must be signed legibly or the EMR record signed electronically.

3. Consultants or providers from any other specialty area shall document their clinical impressions and treatments, legibly in the paper medical record with his or her signature or electronic signature in the EMR record.

4. Each visit, the medical record should include, as applicable:
    a. An update of demographic data including but not limited to first and last name, date of birth, date of visit and medical record number and be placed in the designated area of the pages in the paper medical record or designated fields of the EMR

5. The practitioner(s) shall be responsible for documentation of the following subjective and objective findings within 72 hours of the visit with his or her signature:
    a. chief complaint or reason for the visit;
    b. vital signs;
    c. comprehensive medication reconciliation as appropriate to the specialty and reason for the visit;
    d. summary list, as appropriate, including chronic problems and food and drug allergies
    e. documentation and findings of assessments, as appropriate, including pain;
    f. diagnostic and therapeutic procedures, tests and results with the practitioners' notation to indicate review of those results;
    g. conclusions or impressions drawn from the history and examination, including diagnosis or conditions;
    h. treatment rendered, including essential details of procedures and medications given;
    i. relevant patient education with patient's understanding of education;

j. reassessments as indicated;
k. all diagnostic and therapeutic orders;
l. consultation reports;
m. All addendums or corrections made to the medical record will be recorded as the actual date of notation, not date of service.

6. All items in the EMR including but not limited to diagnostic test results, signature requests, phone notes, prescription refill requests, etc., shall be reviewed and signed within 72 hours of its posting.

7. All corrections to the paper medical record will be made with one single line through the documentation, initialed and dated. Documentation in the medical record is to be completed within 72 hours of the visit. Services must be documented prior to billing. See HSC OP 52.07, Billing Compliance Plan.

8. Personnel assigned by Clinic Administrators will print weekly EMR reports identifying records which have not been completed and signed within 14 business days of the corresponding visit. Physicians will be contacted by Administrators requesting urgent completion of delinquent records. The Department Chair will be notified immediately by the Administrator of a physician's continued non-compliance with this policy.

9. Medical Records should be reviewed periodically in accordance the Performance Improvement Plan.

10. Paper charts should be returned to the designated Custodian of Medical Records no later than 72 hours after date of service to increase the availability of the medical record for patient care, completion and ensure patient confidentiality.

11. TTUHSC employees shall protect the confidentiality of clinic medical records as required by the law. See HSC OP 52.09, Confidential Information.

12. It shall be the policy of the Medical Records Department to release information at no charge after receiving a HIPAA compliant written authorization from the patient for the purpose of continuation of treatment and/or healthcare management operations.

13. Practitioners who repeatedly fail to adhere to this policy shall be subject to corrective action.

Policy Number:	**EP 5.1**	Original Approval Date:	**12/2013**
Version Number:	**2**	Revision Date:	**5/2015**
Signatory approval on file by:	Michael J. Romano, M.D. Associate Dean of Clinical Affairs Clinic Operations Committee Chair Paul L. Foster School of Medicine		