Texas Tech Physicians of EL PASO

Ambulatory Clinic Policy and Procedure

Title: **MANAGEMENT OF MEDICAL RECORDS**	Policy Number: **EP 5.1**
Regulation Reference:	Effective Date: **04/2024**

Policy Statement:

It is the policy of the Texas Tech Physicians of El Paso (TTP-EP) 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 TTP-EP clinics.

Procedure:

1. The Texas Tech Physicians of El Paso Clinics Medical Record is composed solely of the contents of the institutional Electronic Medical Record owned and maintained by TTP-EP. Paper forms will be limited exclusively to situations where an electronic form cannot be used to meet the intended purpose or is highly impractical. Paper forms and paper records from other sources must be scanned into the EMR and the paper original destroyed. The data contained in electronic forms is the final and valid information of the medical record at any time that a paper form scanned into the EMR contains data that belong to an electronic form.

2. The patient's clinic medical record shall be completed and signed electronically in the Electronic Medical Record (EMR), or legibly in blue or black ink for paper forms that require signature, by those involved in the patient's care each visit.

3. Teaching Physician documentation shall reflect appropriate presence and participation for each visit when resident staff and/or medical students are involved in the patient's care.

4. The practitioner(s) shall be responsible for completing documentation or review of the following pertinent and relevant subjective and objective findings within 72 hours of the visit by applying 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. active problem list, as appropriate, including on-going 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 recommendations;
   m. All addendums or corrections made to the medical record will be recorded as the actual date of notation, not date of service.

5. Documentation need not be excessive or redundant to the information already contained in the chart, i.e., notes best focus on the medical decision making with the relevant history, physical and other tests supporting the medical decision making.

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 (3 business days) of its posting.

7. It is the responsibility of all practitioners to designate the practitioners who will review and sign documents in their absence, not to include visit notes.

8. Practitioners departing the institution or discontinuing practice in the Clinic, and the Department Chair are responsible for formally designating the practitioner/s that will become responsible for review and signature of all items in the Medical Record that are received after the practitioner's departure. The Department administration will be responsible for the adjudication of any item left outstanding by a departing practitioner. See Appendix 1: Memo: Provider Transition of Care Assignments.

9. All corrections to a paper form 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.

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

11. TTP-EP employees shall protect the confidentiality of clinic medical records as required by 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.

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Signatory approval on file by:	Juan Figueroa, M.D. Director of Clinical Operations Clinic Medical Directors Committee, Chair Texas Tech Physicians of El Paso Alejandra Ruiz-Sullenger, MHA Unit Associate Director, Medical Records	Alejandra Ruiz-Sullenger	