JNP

"Let the Record Speak . . .": The Power of the Medical Record

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ABSTRACT

Nurse practitioners (NPs) know the medical record is their essential source for clinical information and that a medical record accompanies every patient and each encounter is documented. As a primary legal document, the medical record is usually the best source of evidence. In addition, it communicates and stores data including protected health information. Legal implications innate in documentation relating to reimbursement, fraud and abuse, and data breach are key areas impacting NP practice. The aims of this article are to enhance NPs' understanding by exploring some essential functions of the medical record, thereby decreasing their risk of liability.

Keywords: billing, documentation, fraud and abuse, medical record, protected health information, qui tam

"If it wasn't charted, it wasn't done" is a familiar adage that rings clear in the memory of most nurses. Although the evolution of technology has changed the manner and means of documentation, the medical record remains as central to nursing today as Nightingale's *Notes on Nursing*. In nurse practitioner (NP) practice, an accurately documented medical record generally correlates with safe nursing care but may go even further. In a claim of negligence or malpractice, the medical record provides "the primary source of evidence" illustrating whether key elements of the allegation(s) are met. The medical record substantiates compliance, level of service, and diagnostic coding accuracy. In monitoring care, the medical record measures outcomes and in statistics offers data support. This article will review many of the legal implications innate in documentation; emphasize its importance in issues relating to reimbursement, fraud, abuse, and data breach; and offer specific suggestions for improvement. The aims are to enhance understanding of the practicing NP by exploring some of the essential functions of the medical record (henceforth abbreviated to "the record" or "record") and to decrease the NP's risk of liability.

DOCUMENTATION'S DOUBLE EDGE

Although most professionals dislike "paperwork," consider its essentiality in NP practice. Documentation establishes the diagnosis, outlines the treatment trajectory for evidence-based care (including referrals and consultations with other disciplines), monitors prescribing practices, substantiates quality in the provision of care, ensures legal authoritative lines (eg, delegation of care and collaborative practice settings), and is essential to billing and reimbursement. Furthermore, documentation serves a role in preserving the history of the NP and in the writing of the profession's future. It shows evidence of advanced practice and denotes position as "provider" to patients and colleagues. Lastly, it offers a road map for the future through policy and leadership as its clinical champions write standards of care and principles of practice.

Various health care laws and regulations regarding medical records are found at federal, state, and organizational levels. Because federal law is preemptive over state, some laws will be consistent nationally, whereas state laws may vary (eg, practice autonomy). Most laws and/or regulations portend a similar purpose—the safety and well-being of the consumer (the patient). The American Health Information Management Association defines the legal health record as a business record owned by the organization and composed of "individually identifiable data in any medium, collected and directly used in documenting healthcare status."[1]

THE PATIENT'S RECORD: UP CLOSE AND PERSONAL

A record should exist on every patient, and every encounter should be documented. Under federal regulations, such as those outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all providers in federally funded clinics must ensure a legal health record (the record) is generated by all patient encounters. In addition, the Joint Commission's standards require that a record exist on each patient. Finally, the American Nursing Association's standards and principles of documentation expect that the record is "one" central data source where multiple users make entries.

The individualized patient record is typically a collection of actual and potential health care problems identified by the health care multidisciplinary team of medicine, nursing, allied health, and other disciplines. In it, the NP will find information obtained from admissions and discharges from various facilities including transfers, treatments and rehabilitation, and ongoing monitoring of care within the present facility and beyond discharge. Its contents may include documentation of actual care delivery, legal permissions, consents, personal data and demographics, a complete assessment, plan of care, ongoing observations, the patient's responses to interventions, a register of the administration of medications, treatments rendered, services ordered and consumed, and multiple other types of information all germane to nursing's (and the NP's) professional role.

The record is a potential repository of all of the encounters the patient may have with the health care system and ideally begins before birth with prenatal recordings and ends with death. Record entries should give sufficient justification for admission(s), diagnosis, medications and/or treatments, and the specific plan prescribed. In addition, patient identifiers, demographics, intimate personal details, a description of the hospital course, and the individual responses to treatments reflecting continuity of care between providers will be found.

This unique, patient-specific "narrative" offers the NP a compilation of data provided by a number of providers (typically) chronologically and if modernized in an electronic format. As the traditional paper chart is replaced by an electronic health record, national systematic health information exchange capabilities will improve, redundancy and duplication of services should decrease, and new opportunities to improve patient care and its monitoring will emerge.

Except in very limited circumstances, such as psychotherapy, an individual is entitled, upon request, to access (a copy or a review of) the record, including diagnostic reports such as laboratory and x-ray results, monitoring reports, instructions, and an accounting of charges. Because the record is owned by the agency, any person requesting access is subject to the Code of Federal Regulations (45 §164.524 [a] [1] [i]-[iii] and [2] [i]-[iv]) as well as a number of other federal laws (eg, 1106 Social Security Act, The Privacy Act, § 6103 The Internal Revenue Code, and others). In addition, the individual must follow agency or court procedures (eg, payment of fees) including in some cases subpoena. With patient consent and in adherence with the aforementioned Code of Federal Regulations, HIPAA, and state law, the patient's personal representative (family member, attorney, or designee) may request a copy of a record.[2] The record is subject to discovery in pending litigation because it may support or disprove claims. Because it is a valuable attorney resource, an entire copy may be requested. In some situations, such as those involving administrative law (eg, a worker's compensation case,) the record could be integral to substantiating disability and determining future compensation.

In recent years, increasing fraud and abuse has led to the passage of multiple new health care regulations and sweeping changes in practice management. Documentation has never been more important to the NP. The record may provide the NP with their own defense in a claim of malpractice or fraud. In disciplinary procedures, documentation may determine the outcome of the NP's clinical privileges, whether they will be able to bill insurance and maintain licensure. Although documentation itself does not prevent fraud or ensure patient safety, it can demonstrate facts (eg, that fraud did not occur, that safety principles were followed, that the standard of care was met, and that best practice was rendered). As NPs contemplate the multifaceted purposes of the