The medical record should provide an accurate reflection of the care provided to the patient. It is a legal document scrutinized by both plaintiff and defense attorneys should litigation, a regulatory action or ethics complaint be brought against you. It is important to keep in mind that the patient’s medical record provides a lasting memory of the events and reflects your and the rest of the team’s professional credibility.

Whether the medical record is in electronic or written form, a complete medical record is also critical because it ensures effective communication among providers about the patient, supports billing of services and speaks to the quality of care. In the event of a lawsuit, thorough and complete documentation is essential to the defense of a malpractice case. Keep in mind that you must maintain a medical record. Not doing so is unpermitted, unethical and can lead to a regulatory action against you. Moreover, in the event of a lawsuit, remember that juries do believe that if something was not documented, it was not done.

In psychiatry, a well-documented medical record should include the following:

- Relevant information concerning the diagnosis and treatment
- Assessment of risk of suicide or possible violence towards others
- Medications prescribed, including any associated monitoring
- Informed consent
- Compliance (or non-compliance) with treatment
- Boundary issues
- Termination of doctor-patient relationship
- Consultations requested
- Diagnostic tests performed
- Telephone calls
- Emails/texts

Each state has specific laws addressing how providers must maintain, protect and dispose of records, as well as laws giving patients, providers and others access to medical records. Each practice should establish and follow written policies and procedures that comply with the applicable laws and regulations concerning the creation, maintenance, release and disposal of medical records. Further, keep in mind...
that some states afford a higher level of protection for psychiatric/mental health or records involving substance abuse. It is important that you are aware of the regulations within your state concerning these types of medical records.

Additionally, most states specify that the information in the record belongs to the patient, while the physical record belongs to the provider, practice or facility. As such, providers should not provide patients with the original medical record, but rather a copy when requested, if accompanied by a valid, signed release. However, states may have regulations that the provider may not necessarily release the record to the patient where a summary can be provided in lieu of a complete record or if it would cause the patient emotional harm. Prior to releasing the medical record, should you have concerns, contact risk management to discuss. This is of particular importance in dealing with psychiatric, mental health or substance abuse records.

**What is the Legal Health Record vs. Designated Record Set?**

Questions often arise about the differences between the "legal health record" and the "designated record set" because they both contain information that must be disclosed when requested. The "legal health record" is generally the information used by the patient care team to make decisions about the treatment of a patient. The "designated record set" is generally broader and refers to all protected health information, including business information unrelated to patient care.

It is important to note that neither the "legal health record" nor the "designated record set" includes "psychotherapy notes." HIPAA treats psychotherapy notes differently and does not require they be disclosed provided the psychotherapy notes are kept physically separate from the remainder of the medical record. If the psychotherapy notes are not kept separate, than they must be disclosed if requested. Psychotherapy notes do not include information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests, nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Again, should you have questions prior to releasing the record, contact your risk manager to discuss.

**Medical Record Retention Requirements**

Most states regulate the minimum amount of time that the medical record must be maintained by the provider. For those states that do not designate the timeframe for retention, it is recommended that the records be maintained for at least as long as the state’s statute of limitations for bringing a medical malpractice action. Specific to psychiatric treatment, however, as patients may at times lapse from treatment and resume again, you may consider maintaining your records indefinitely. Maintaining the medical record could be critical if you find yourself involved in a lawsuit for malpractice or a regulatory action.

In addition, medical record retention requirements for minor age patients are most often longer than the retention requirements for adult patients. If a provider retires or relocates during the retention period, patients must be kept apprised of how they may access their records if needed. Providers should also be aware of any additional retention requirements imposed by third party payors, including Medicare and Medicaid, if participating.
Frequently, questions arise about whether paper records must be maintained in paper form or can be converted into an electronic version. Providers should check with their state boards to determine if they permit providers to transfer paper records into an electronic version. If so, providers should take care to ensure that the new electronic version is of sufficient quality, i.e. color documents should remain in color, rather than scanning in as black and white.

**Medical Record Storage/Destruction Requirements**

**STORAGE OF RECORDS**

In addition to retaining medical records, it is important to establish and implement a record retention plan for storage and disposal at the appropriate time. Similar to retention requirements, there are no uniform storage or destruction requirements and providers should check if their state has specific requirements. Medical records should be stored in a manner and location that safeguards the records from damage, theft and unauthorized disclosure.

**DESTRUCTION OF RECORDS**

In general, when destroying records, providers should maintain documentation that includes the following information:

- Date of destruction
- Method of destruction
- Description of the disposed records
- Dates of treatment
- A statement that the records were destroyed in the normal course of business
- The signatures of the individuals supervising and witnessing the destruction

Of course, medical records relating to any ongoing civil, criminal or regulatory action should not be destroyed until the retention period is satisfied and the matter is fully resolved. Additionally, providers should consult with their local attorney and/or accountant concerning retention requirements for other types of business documents.

If record storage/disposal is contracted out to a third party, the HIPAA Privacy Rule requires that a business associate contract exist between the provider and the company, which establishes the permitted and required uses and disclosures. It must include the following elements:

- The method of destruction or disposal
- The time that will elapse between acquisition and destruction or disposal
- Safeguards against breaches of protected health information
- Indemnification for the organization or provide for loss due to unauthorized disclosure
- Requirement for the business associate to maintain liability insurance in specified amounts at all times
The Role of the Medical Record in a Malpractice Claim

There may come a time when a patient brings a claim against you for the care which you provided. Regardless of the type of claim brought against you, the medical record will play a major role in successfully defending yourself, and in some cases, even prevent a claim from going forward.

Keep in mind that even when allegations are baseless, the mere fact that you have been named in a lawsuit is likely to add stress and anxiety. You may have to reschedule patients on multiple occasions because of the legal proceedings and, in the event that the case goes to trial, you will likely need to take one to two weeks out of your practice to prepare for and attend the trial. Assertions of malpractice can cause professional embarrassment and prolonged stress as some cases may drag out for several years.

When documenting, it is important to do so with both the patient and a jury in mind. A good rule of thumb is to document objectively and only use the facts and clinical opinions that are relevant to the diagnosis and treatment of the patient.

When documenting, it is helpful to:

- Use direct patient quotes when describing a situation or exchange
- Avoid using opinions, personal comments or conjecture
- Use objective, descriptive language that describes the patient’s behavior and actions. Avoid general, non-descriptive terms such as: “hypochondriac,” “litigious,” “cry baby,” “tendency to complain,” “patient is a friend of”
- Frivolous comments also have no place in patient records. It is important to remain objective in your documentation.

HOW MUCH DOCUMENTATION?

There is an on-going debate within the psychiatry profession regarding how much documentation should be included. Generally, the inclusion of the following areas should be considered on a case-by-case basis, and may not need to be included, unless relevant to patient treatment:

- Detailed account of sexuality/sexual behavior
- Interpersonal conflicts
- Issues that may be embarrassing to the patient if disclosed
- Third party names
- Criminal behavior/history

Receiving a medical records request from an attorney is often one of the first signs that a patient may be preparing to file a lawsuit against you. A well-documented medical record may prevent a lawsuit from being filed. A plaintiff’s attorney will review the medical record for evidence of negligent care, specifically looking for:

- Holes & omissions
- Conflicts & contradictions
- Admissions
- Altered records
- Legibility issues
It is important to note that altering/tampering with medical records may make a defensible case indefensible. Moreover, most professional liability policies will not cover claims where fraud is alleged and generally the statute of limitations will not apply in cases involving allegations of altering/tampering. The following actions may give rise to a claim of altering/tampering with medical records:

- Adding to an existing record
- Recording inaccurate information
- Pre-dating record
- Re-writing/altering
- Destroying the record or an entry (also referred to as spoliation)
- Adding to someone else’s notes

In addition to evidence of altering or tampering with a medical record, the plaintiff’s attorney will also look for late entries, corrections, addendums, unclear orders, orders not followed-up on and invalid consent. When correcting or adding to a record it is important that the entry is labeled as such and does not give the appearance of trying to “hide” information.

When looking for information to build the case against the provider, the plaintiff’s attorney will:

- Compare the medical record with the billing record
- Compare different provider’s notes contained within the record
- Compare different providers’ observations
- Detect changes in style of note writing, i.e. longer note on the day of the incident
- Look for entries recorded out of chronological order
- Correlate staffing/time sheets to detect documentation by staff not on duty on the day of the incident
- Interview ex-employees

In addition, with respect to electronic records, the attorneys will also analyze audit trails of computerized order entries and review the metadata contained in the record.

**Conclusion**

The well-documented record not only serves as the official record of the patient’s treatment, it also can be your biggest asset if defending a malpractice, regulatory action or ethics complaint. Psychiatrists should understand their state’s laws and regulations concerning medical record formation, retention and disposal, as well as laws protecting patient confidentiality.

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1 American Health Information Management Association, “Fundamentals of the Legal Health Record and Designated Record Set,” (www.ahima.org).
2 Id.
3 Id.
Medical Records: Protection for the Psychiatrist and the Patient (continued)

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