

## **ELECTRONIC MEDICAL RECORDS:**

### **FRIEND OR FOE?**

*Every health care provider must develop and master habits which make electronic medical records an adjunct to patient care and professional success. To do less will invite lawsuits, risk regulatory investigations and render medical care injurious, ineffective or unproductive.*

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## **ELECTRONIC MEDICAL RECORDS: FRIEND OR FOE?**

*Every health care provider must develop and master habits which make electronic medical records an adjunct to patient care and professional success. To do less will invite lawsuits, risk regulatory investigations and render medical care injurious, ineffective or unproductive.*

Since electronic medical records (EMRs) are now mandatory, understanding how these systems can be used to the advantage of a health care provider is the subject of this paper. Why is such a discussion important? Hopefully, it will lead to an understanding that documentation is considered an *essential component of medical care*. As the title suggests, correct use of EMRs can benefit a health care provider as exemplary care is contemporaneously recorded. *Documenting* thorough examinations, memorializing critical consents, explaining clinical decisions and confirming the instructions given, is almost *as important as doing the tasks*. Recordkeeping isn't a menial task intended to burden and frustrate health care providers, it is a part of good care.

To best understand the practical comments which follow, this paper is presented in four parts. The first discussion will focus on *requirements* of medical documentation according to Texas law. The second part will discuss the special *status* given to medical records when used in evidence to prosecute or defend any lawsuit involving medical care. The final portions of this paper will endeavor to *illustrate* some bad habits and *give practical suggestions* designed to help the health care provider habitually produce and maintain excellent medical records.

Good electronic medical recordkeeping can avoid as many as 80% of lawsuits threatened. Proper documentation can also assure victory in complaints, claims or lawsuits and avoid the battles of credibility which sometimes give rise to unjust or unfair results. Moreover, good recordkeeping can promote and ensure full reimbursement for procedures ordered and avoid the roadblocks used to reduce or delay payment for health care services.

On the other hand, failing to use the electronic tools to complete the delivery of care, or using them in a sloppy, lazy or inappropriate way, can generate lawsuits difficult, if not impossible, to defend. Inappropriate or inadequate use of electronic medical records can also result in significant fines, HIPAA violations, and serious actions from the Texas Medical Board or other regulatory agencies.

## **PART ONE: The Law Defining Medical Records**

### **The Expected Contents of Medical Records**

The Texas Medical Board regulates medical practice in Texas and imposes certain duties and requirements for those who have a license to practice. In a similar way, the Board of Nursing governs what nurses should include in records. When a physician or nurse is confronted with a Board complaint, which gives rise to an investigation, these state agencies are NOT forgiving. The Board rightfully requires proper and complete medical records by any licensee. The detailed content required of every physician is set out below:

#### **TEXAS MEDICAL BOARD'S REQUIREMENTS AS TO CONTENTS OF MEDICAL RECORDS**

Texas Administrative Code, TITLE 22, PART 9, CHAPTER 165, RULE §165.1 (a)

**Each licensed physician of the board shall maintain an *adequate medical record* for each patient that is complete, contemporaneous and legible.**

For purposes of this section, an “**adequate medical record**” should meet the following standards:

- (1) The documentation of each patient encounter should include:
  - (A) *reason* for the encounter and *relevant history, physical examination* findings and *prior diagnostic test results*;
  - (B) an *assessment*, clinical impression, or *diagnosis*;
  - (C) *plan for care* (including discharge plan if appropriate);and
  - (D) the *date and legible identity* of the observer.
- (2) *Past and present diagnoses* should be accessible to the treating and/or consulting physician.
- (3) The *rationale for* and results of diagnostic and other ancillary services should be included in the medical record.
- (4) The patient's *progress*, including *response to treatment*, *change* in diagnosis, and patient's *noncompliance* should be documented.
- (5) Relevant *risk factors* should be identified.
- (6) The written *plan for care* should include when appropriate:
  - (A) *treatments* and *medications* (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
  - (B) any *referrals* and consultations;

- (C) patient/family *education*; and
- (D) specific *instructions* for follow up.

(7) Include any *written consents* for treatment or surgery requested from the patient/family by the physician.

(8) Include a summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.

(9) *Billing codes*, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.

(10) All non-biographical populated fields, contained in a patient's electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics or assessments as documented by the physician.

(11) Any amendment, supplementation, *change*, or *correction* in a medical record not made *contemporaneously* with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.

(12) Salient records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.

(13) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient's status. Paragraphs (1) - (12) of this subsection *may* be modified to account for these variable circumstances in providing medical care.

Needless to say, the content required by the Board is broad, detailed and comprehensive. The requirements of the Board of Nursing are not quoted here, but are equally comprehensive.<sup>1</sup> Some of the necessary items (prior meds, billing codes, consult reports and consents) may automatically be included in an electronic medical record. However, the information described in items (1)

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<sup>1</sup> Attached as Item 1 to the appendix of this paper. Texas Administrative Code, Title 22, Part 11, Chapter 217, Rule §217.11.11(1)(D) and Rule §217.12(1)(C)

through (7) require the physician's direct input. The need for records to be created *as a part of the care* provided is paramount.

The internal clock running in the background of every EMR system is unforgiving if the *practitioner* delays in completing the record or leaves the entry open indefinitely. When records are scrutinized by a reviewer, the doctor will be bound by the internal time stamp recording the entries made. The Board will always take the computer's clock over the testimony of the most trusted or credible doctor. If a health care provider never "completes" or closes an electronic medical record, the logical next question is why not? If a regulatory agency sees any errors, it presumes the record and record keeper are deficient.

Delays in completing records are also viewed with suspicion by any reviewer of the records. At best, the suspicion will lead to an understanding of innocent tardiness arising from the number of patients seen or the demands of a busy practice. However, the records could be interpreted as sloppy, incomplete or inadequate due to shortcuts used by an overworked practitioner trying to see too many patients. At worst, the delay could be viewed as an attempt to hide, change or use the records to commit fraud against the patient, the government or insurer paying for the service.

Lawyers who sue health care providers typically allege that poor record keeping is an intentional effort to deceive. It is not uncommon for a crafty lawyer to get the healthcare provider to agree that "if something is not written down, it did not happen." Once that premise is accepted by the practitioner, the lawyer then uses the impossible standard to condemn the practitioner of inadequate care by limiting the acts of the provider to only the items specifically mentioned. When the records are complete, the same lawyer will condemn the entry that "it would be impossible for all of the things in the record to have been done." For example, the accusing attorney will describe notes containing "no complaints" or listing every parameter as "WNL" sinister diagnosis of "CYA" by the author of the note.

All these reasons should compel the health care provider to always take the time necessary to *routinely and habitually complete records immediately* after the service is rendered. It is not just busy work meant to slow the doctor down from providing care, it is an essential part of completing excellent care. If done correctly, following the content requirements mentioned above are very valuable.

### **The Increased Importance of Medical Records**

Many health care providers fail to understand the significance of how electronic medical records are used and consequently, do not understand the critical importance of this paper's thesis statement for success. Electronic medical records recording excellent and complete medical care assures proper communication with other health care providers essential for the continuation of a care plan. Good records can prevent questions by insurance or governmental

agencies and bypass red-tape and bureaucratic obstacles to secure payment for services. Every other aspect of administrative or collection activities goes better with good recordkeeping habits.

The provision of medical care, while it may be efficacious to the patient and brilliant, is meaningless unless there is proper documentation of the history, clinical data, description of procedures, discussion of differentials, and description of a care plan. The days of “taking the doctor’s word for it” have passed. Health care providers who have habitually ignored or resisted the move to electronic medical recordkeeping are kidding themselves if they believe they can finish out a successful career by living in the past.

Each health care provider should return to their training and conjure up visions of a tough mentor or professor, adept at the didactic method of teaching, who would test and ridicule any assumptions or conclusions relied upon by the physician or nurse in training. Medical records should contain the *essential rationale* as to how a health care provider arrived at a particular diagnosis and *recite the basis* necessary to support such a diagnosis. Cutting and pasting the prior health care provider’s history while omitting the current changes, is wholly insufficient. The initial history is almost always inaccurate the first time it is copied and pasted in the next note because it omits new important facts. The temptation to take shortcuts by simply copying and pasting a prior entry is hard to resist. It may look good, but is deficient. In fact, such conduct causes the integrity of the entire record to suffer.

## **PART TWO: THE SPECIAL EVIDENTIARY STATUS OF MEDICAL RECORDS IN LITIGATION**

### **The Value of Medical Record Evidence**

Few health care providers understand that statements recorded in medical records enjoy special protection and are assured admissibility by most Courts in the United States. The courthouse uses an adversarial system to find truth. The Rules of Procedure and Evidence are limits imposed to make the system fair and reliable.<sup>2</sup> Both the Federal Rules of Evidence and the Texas Rules of Evidence define medical records as exceptions to the “hearsay rule” which enables statements contained in records to be used in a highly effective manner should there ever be any consideration of a physician’s care during a trial.

*Hearsay* is a statement purportedly made by someone else at a time when they are not under oath, which is used to prove the truth of the matter asserted. In other words, a statement made by an individual, other than the witness, cannot be used

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<sup>2</sup> A complete copy of TRE Article VIII, The Texas Rules of Evidence (Rules 801 – 806) are attached as Item 2 to the appendix of this paper.

by that witness because they are not the “declarant” or the one who actually made the statement.

The hearsay exclusion has been a fundamental component of evidence law and is based on the fact that if a statement is sought to be introduced in evidence, the person who made the statement should be the one who reports the statement so the veracity of that witness can be tested by cross-examination.

The purpose of the rule is designed to permit only *trustworthy* evidence to be heard by the jury. In our adversarial system of justice, the trustworthiness of evidence is determined by how a person delivers the information after the veracity of the evidence is “tested” or proven to be true by cross-examination.

Medical records and statements of history, diagnosis and treatment contained in medical records actually meet the definition of hearsay. As such, the statements are excluded by the rules or are deemed inadmissible. Unless some evidentiary rule created an exception, no statements relating to history, diagnosis or treatment could ever be referred to in Court. The patient and/or physician would have to be called as live witnesses. Even then, each witness would be limited to testifying, in large part, to only what each individual actually said and not words that were spoken by the other.

The Rules of Evidence, however, create a unique exception to the hearsay rule which exempts certain statements from inadmissibility. Statements recorded in medical records *are not excluded as hearsay, regardless of whether the declarant is available as a witness.*

The hearsay rule and exceptions are identical in both the Federal and Texas Rules of Evidence which reads as follows:

**Rule 802: The Rule Against Hearsay**

Hearsay is not admissible . . . unless otherwise provided by these rules.

**Rule 803: Exceptions to the Rule Against Hearsay**

- (4) **Statements Made for Medical Diagnosis or Treatment.** A statement that:
  - (A) is made for – and is reasonably pertinent to – medical diagnosis or treatment; and
  - (B) describes medical history; past or present symptoms or sensations; their inception; or their general cause.

The reason the exception exists is because the law presumes that a patient is always truthful when talking to their physician about a medical issue or expressing facts to the physician. It also assumes that the physician or health care provider is dutifully and contemporaneously recording those statements in medical records at or near the time the statements are made. Even the health care provider's statements are presumed to be truthful and complete. ***This is a unique level of trustworthiness not given any other profession.*** This presumption arises from a strong belief that in matters relating to life or death, individuals seeking help will be truthful to a trustworthy provider who cares for the patient and committed to do no harm. In other words, the principles of evidence law supporting the admissibility of the statements is based on the fact that a patient is going to be truthful to their physician and that a physician is going to be careful and accurate in recording information in the medical record.

This unique status is also based on the important fact that the statements are recorded contemporaneously. That is, the principle is based on the fact that this recordation of statements, symptoms, diagnoses, and assessments is done at or near the time the statement is heard or the condition is observed.

Because medical documentation is presumed to be accurate and trustworthy, statements contained in such records can be read to the jury or introduced into evidence because there is no need to test their veracity by cross-examination. Health care providers fail to recognize this unique advantage and often fall into bad habits allowing medical records to be used as a tool against them when they are accused of medical malpractice.

### **PART THREE: UNUSUAL “CHARACTERS” AND OTHER PROBLEMS CREATED BY EMRS**

Purchasing, installing and maintaining an adequate EMR system is a large investment for a hospital or medical practice. Because such systems are being forced on the medical community, the sellers of EMR software programs have a constant source of buyers. Most solo practice physicians are being forced to join a group in an effort to share this expense. Proper use of an EMR system by a multi-physician group can bring great benefits. Consolidation of tests and data with updates being carried forward automatically is convenient. However, new problems arising from inadequate “pick and click” menus, lengthy detailed templates, or mindless “cutting and pasting” of data may obscure real clinical information. Repeating invalid diagnoses proven to be wrong may also lead to problems.

The EMR revolution has given rise to problems as the transition from paper to electronic data occurred. These problems come from generational differences, inflexibility of templates, or from a lack of medical knowledge on the part of the EMR designers.



## **The Unusual “Characters” who now make Entries in Medical Records**

The use of EMRs gave rise to certain types of strange documenters as the transition from paper to electronic data was made. These characters have always been around, but now they are more dangerous than ever. These trouble makers are identified below.

### **1. The “Procrastinator”**

The Procrastinator is a health care provider who has made the decision to continue to generate records as they have for years and duplicate efforts by creating a completely separate EMR, after the fact. This leads to problems since it doubles the work load for the physician or nurse and creates an impossible task. Either the original records will survive and the EMR version of the chart suffers, or the EMR version of the chart is so out-of-sync with other facts that it does not pass muster as valid medical documentation.

### **2. The “Conscientious Objector”**

This is a physician or nurse who decides to resist change by refusing to acknowledge that computers exist and continue their old ways until it is too late to change. This is what also happened to the dinosaurs.

### **3. The “Inventor”**

This is a health care provider who does not like any electronic medical record platform or format, and decides to create their own special template. They create a special Word document which is feverishly copied and completed so it resembles an EMR. If they don't forget to “save” it as a separate item, they fail to remember to scan it into the correct folder of the EMR later which creates problems. They likely stockpile records to allow the earbud wearing teenage son of a co-worker to do the scanning for minimum wage during the summer or Christmas holidays.

### **4. The “Checker”**

This is the health care provider who does not give any information, but is enamored with the number of “pick and click” menus that exist. They simply place checks in various boxes. This quick checking is what a failing high school student does when taking a multiple-choice test. Because they believe they might accidentally guess the correct answer they quickly bubble in answers to the last 17 questions before the bell rings.

## **5. The “Robot”**

The Robot is the health care provider who responds to electronic medical records by simply repeating the same verbiage for every patient, regardless of important changes in clinical circumstances. The feds are actually after this person.<sup>3</sup>

## **6. The “Paster”**

This health care provider loves the ability to cut and paste entries of other health care providers, and believes by doing so, there is sufficient quantity contained in the record to cover-up the lack of any new or meaningful information. This person perpetuates the initial histories and diagnoses long after they become irrelevant and erroneous. This explains why Robin Williams is always referred to as a female in his medical records. It happened when the health care provider who completed his first intake form entered the wrong sex by mistake and it has been automatically repeated in every subsequent record.<sup>4</sup>

## **7. The “Mind Reader”**

This health care provider takes the liberty to speak about the thought processes or motives behind the clinical judgments of other health care providers. These individuals editorialize about why other specialists made the decisions relating to the plan of care. “The testing was not indicated because Dr. X didn’t want to examine the patient due to her yoga class.”

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<sup>3</sup> Modern Healthcare: Justice Department and HHS jointly published an open letter to health care providers in September 2012 warning that there are indications some companies were using the technology to game Medicare. Critics say functions such as cut-and-paste make it too easy to bill for work that wasn't actually performed, especially when the borrowed material comes from a different patient's record.

<http://www.modernhealthcare.com/article/20131210/NEWS/312109965>

<sup>4</sup> Modern Healthcare: Justice Department and HHS also stated that cut-and-paste is also implicated sometimes in problems with the quality of care, such as when incorrect information gets entered into a patient record by mistake. “Every once in a while, a 75-year-old gentleman will turn into a 30-year-old woman, on the basis of cutting and pasting the wrong information into the chart,” said Dr. William Bria II, chairman of American Medical Directors of Information Systems. “I’ve seen this personally.”

On Tuesday, HHS' inspector general released the first of two new reports on fraud vulnerabilities in EHR systems, concluding that too few hospitals have policies defining the proper use of cut-and-paste. A voluntary survey of all 864 hospitals that had received subsidies for the EHR systems as of March 2012 found that only 24% of hospitals had any policy regarding improper use of cut-and-paste.

<http://www.modernhealthcare.com/article/20131210/NEWS/312109965>

## **8. The “Court Reporter”**

This health care provider does not even attempt to discern the clinical significance of information in medical terms, but attempts to quote every statement made by the patient or other health care provider verbatim. These records have quotation marks everywhere so every fact is undefined and suspect. What really happened when the record says: The patient reports “no” fever, N or V, but flushed vomitus that “appeared” to have blood in it. He now complains of “excruciating” pain but says “it is not as bad as the worst pain he has ever had.” (So what really happened?)

## **9. The “txtr”**

The “txtr” is a typically young health care provider who abandons the communication tool EMRs provide in favor of shortcutting the process by simply texting clinical data via cellphone to physicians or others. This is not only a HIPAA violation, but deprives others who rely on the medical record of important information because they are not copied on the text messages. These practitioners are in the dark about new developments.

The txtr also thinks that nothing written on one’s telephone will ever see the light-of-day in a courtroom. A subpoena for cellphone records is a common event in every case. This prompts messages like, “you better get in here - I don’t think you will want to explain this fetal monitor strip to a jury.”

The txtr also wrongfully believes HIPAA violations are avoided because names are left out of the messages. Txtrs then wonder why there was a medication error when they ask: “Give Methotrexate?” believing they typed “give message?” and the auto-speller took over the patient’s care.

In the rare circumstance when a text is necessary, the text should be mentioned and timed in the medical record and, if possible, quoted so as to include the communication as part of the documentation.

## **10. The “Time Traveler”**

The Time Traveler is a mysterious health care provider who decides to document the events of the past 12 hour shift in notes made during the last 30 minute period. In other words, at the end of the day, this provider travels back in time and recreates events which occurred earlier according to their recollection. Their entries document the vent stings *after* respiratory therapy removed the ET tube.

These time travelers fortunately have a flawless memory. However, sometimes entries pertaining to one patient are erroneously placed in the chart of another. For example, when a comatose patient “had no complaints and verbalized understanding” one will wonder why the physician or family wasn’t informed of a miracle. Obviously the veracity of the record is questionable.

In the time-traveler's defense, it is true that they sometimes get things correct. After all, charting "condition remains unchanged" 12 hours after the patient died is technically correct.

### **11. The "Rambler"**

This health care provider decides to err on the side of quantity rather than making a qualitative assessment of what information should be contained in a medical record. By needlessly recounting inconsequential items, the serious changes or significant medical events are obscured and fail to receive the attention needed.

### **12. The "Evil Crossing Guard"**

This is a health care provider who loves to make comments in the chart which throw other health care providers directly in front of a fast-moving bus. This person is a favorite of attorneys who make a living by suing health care providers. This practitioner often receives a gift from plaintiff's attorneys at the end of the year or offered a "secret consultant" job by the law firm that sues health care providers. These documenters also receive notoriety for having their entries in the medical records enlarged bigger than everyone else on video screens seen by juries.

### **13. The "Un-Terminator"**

This is a health care provider who never gets around to finishing a note. They leave the entry open in the computer such that the clock inside the EMR system records that the health care provider spent 6 months, 3 days, 2 hours and 37 minutes to complete an important patient encounter. Not closing an entry in a computer can throw others under the bus and also give to claims that the record has been altered.

The serious problem created by the Un-Terminator merits a little more discussion.

### **Failing to Sign Off On or Close an Entry Puts the Practitioner at Risk**

Failing to "close" an electronic entry in a timely manner creates problems for every health care provider who cares for that patient for the following reasons:

#### **1. Failing to close the record violates the Medical Practice Act's description of what a medical record must be.**

If a complaint is filed on an unclosed record and sent to the Texas Medical Board, the physician could be sanctioned and disciplined for not maintaining timely, contemporaneous records. *The sanction could be given even if the medicine practiced was absolutely perfect.* Sanctions for record deficiencies are by far the most common disciplinary action taken by the Board. The Board can almost

always find fault with some aspect of the physician's records. This prompts a fine and disciplinary action consisting of at least a risk management and records CME.

**2. Failing to close the record also undermines the integrity of the entire record.**

From the earlier discussion, you can see that the Rules of Evidence give credence to a practitioner's entries mainly because they were contemporaneously recorded. Leaving a record open destroys this legal presumption and leaves the records open for a claim that the entry was left open for a sinister reason. If a medical record, which has been left open, is copied and produced to a subsequent treating physician outside the group, or if another Clinic physician participates in the care, it prevents the record from being complete and raises red flags on the EMR system.

Failing to close any entry is never necessary or a good idea. If later information is learned, an addendum entry can always be made. Leaving these records open, even if discovered on an unrelated chart produced by some other physician, will put that hospital or physician's practice on watch-list of any regulatory agency.

**3. Leaving the record open also allows allegations to be raised by adversaries that the records are fraudulent.**

A common tactic for attorneys investigating a lawsuit is to have the injured or unhappy patient, (or the patient's litigious family member), innocently request a copy of the records. After reviewing these records, the lawyer thinks a case *might be worth pursuing* so he or she sends a *Notice of Claim* letter to the physician involved with a **second request** for the records to be produced.

The attorney already has the records, so why is a second request made? The law requires the *Notice of Claim* letter to include an authorization and requires a second production of the records. The attorney about to file a lawsuit will carefully review each and every page of the second set of records produced to see if any entry was changed. The attorney will also be very interested if certain pages or parts of the record were included in one copy and not in the other.

Here is a scenario which an unclosed record can create:

A patient with a complaint against a hospital or health care provider contacts an attorney to see if a lawsuit is justified. To investigate the complaint, the attorney has the patient request medical records from multiple health care providers who have cared for them. The innocent request for records is processed by the "summer help" at the doctor's office in a sloppy or incomplete way. The record given is not complete and contains copies of

electronic entries that were *never closed or signed* are copied and produced.

Then a Notice of Claim letter is sent, the possibility of a lawsuit is raised, and the records are produced *a second time*. The physician is now worried about a potential claim, and may go back in and complete the open entry. When this is done, the date of the change will be automatically recorded *later* than the notice of claim. This late closure of the record (no matter how innocent the change) will be viewed as a fraudulent entry. Anything added will be seen as a self-serving protective statement and will be used to condemn the doctor.

Requesting the “audit trails” saved in the EMR system is in any lawsuit. The date and time the entry is closed is recorded and cannot be changed. Therefore, the “late entry” will be discovered and exposed.

The scenario described above will raise the legal doctrine of “spoliation.” *Spoliation* is when a medical record is altered or destroyed when litigation is threatened. When even innocent spoliation is found, the judge is able to give an instruction advising the jurors that everything in this record should be disregarded and presumed to be adverse to the health care provider. In other words, the entire record is declared “unreliable” by the judge, and the jury is instructed to disregard any favorable comments which may serve as a fundamental part of the physician’s defense.

This is devastating in a lawsuit and almost assures that negligence will be found or that a large judgment (based upon more evil intent) could be reached by the jury.

Unfortunately, this problem does not just fall on the physician who may have failed to close the entry, and completed it at a later time, which is recorded by the internal clock of the EMR. Records left open can hurt *every physician* who authors records for that institution or practice. Once it is known by attorneys who handle personal injuries claims, that specific practice will be targeted as a provider that has questionable or vulnerable records. This will generate lawsuits and become valuable to those who seek to profit when an untoward outcome occurs. Just imagine what the Joint Commission or Medical Board would do if an institution gets a bad reputation for substandard records!

#### **4. Leaving a record open hurts even if a lawsuit is not filed.**

Oftentimes, records are requested by insurance companies, governmental agencies or other regulatory agencies. If the entry has been changed at the time it was closed, this discrepancy is called to the attention of the reviewer. If that reviewer is a person who works at the Texas Medical Board, an independent investigation

can be launched *even without* any patient complaint. If that reviewer is a governmental payee or payor, or an insurance company payor, it may prompt an internal memo which delays payment of every charge submitted by that provider. When records lose credibility, it could cost thousands of dollars in just delayed payments alone and could be devastating if large reimbursements are disallowed because of these record inconsistencies.

### **Future-Shock: More Audits of EMRs are On the Horizon.**

Like it or not, the many ways EMR's will be used in the future are frightening. EMR systems, now mandated by the Texas Medical Board for almost all records, are soon going to be something which can be *audited* by the Medical Board, or some other governmental regulatory agency. The Medical Board, insurers or governmental benefit programs, are only one step away from not only requesting medical records and billing, but will soon request the "audit trails" which show how and when entries were opened and closed. The audit will likely flag repetitive "cut and pasted," entries.

This is already common practice among hospitals and why hospitals require such severe penalties and push physicians to complete their records within a certain period of time. Losing staff privileges for record abnormalities used to be laughed off as the bane of an effective and busy practitioner forced on them by hospital administrators more focused on paper than patients. This is now a tool which can be used against the practitioner.

Open or unsigned records could give a hypercritical auditor reason to reject the record, or use the deficiency as an excuse to delay or reduce reimbursements for services provided. Having records which are above reproach, complete and timely will prevent a host of problems generated by open-ended records.

## **PART FOUR: PRACTICAL APPLICATION**

Equipped with the information above, the practitioner should endeavor to maintain the good habits developed through years of practice but adapt these habits to allow EMR documentation to be a friend as opposed to a tool which calls the physician's credibility or motivations into question. Practical ideas are unlimited, but good habits which have to be in the Top-Ten are listed below. Implementation of these ideas should prompt the practitioner to develop and maintain these *compulsive* routines:

Ten Good habits:

- 1. Complete documentation *simultaneously* with care or as soon thereafter as possible;**

2. **If possible, do the documentation *in front of patient* asking for *confirmation* along the way;**
3. **Give meaningful and accurate histories stating clinical facts *in order of significance or importance*;**
4. ***Use every resource or tool available* to enhance documentation (scribes, dictation equipment, voice recognition software);**
5. **Record discussions with other providers and *inform them* you have recorded their communication in the chart;**
6. ***Avoid* copying and pasting outdated histories or exams from other parts of the record. If information is simply repeated, explain *why* it is included;**
7. **Don't forget to mention consents, warnings, tests, results and consultations;**
8. **Always include a statement about *routine activities* which happen during every visit. (“patient’s questions were answered,” “plan of care reviewed again at time of discharge” or “patient told to return if new concerns arise.”);**
9. ***Timely close and sign* the record (remember, the internal clock is running and doesn't lie); and**
10. ***Confirm* the patient’s understanding of instructions and use of medications in the record.**

Practical suggestions in dealing with EMR prompts:

If the physician wants to cut and paste a prior history, mention that the information came from a previous record and follow it with a statement of any new findings. Brief statements at the beginning and end of a previous history could be:

***“The prior history presented by this patient was...”***

(prior history)

***“Updates to the history at the time of this examination include...”***

To avoid cutting and pasting a previous summary, but to assure that it can be used if needed, one could also begin a note:

***“The previous history is not repeated, but has been reviewed.***

***The findings and history are unchanged, except...”***

Alternatives to the method stated above would refer any subsequent physician to the prior summary for more details, but only elucidate the new information as of the time of that health care provider’s examination. For example, a record which begins:

***“The detailed history is as above; however, the specific findings relevant to this presentation include...”***



This could be followed with a description of only the pertinent history and/or findings necessary for that patient encounter.

Many EMR embedded templates requires a provider to note by exception to normal any clinical findings. The template then gives the provider an all-inclusive exhaustive list of signs and symptoms. This type of form presents a challenge. For example, many of the normal findings contained in such an all-inclusive list cannot be determined as normal without some specific examination or test. In other words, one cannot check-off a normal neurological exam *unless all of the relevant nerves* have been tested. After completing such a template it may be appropriate for the physician to leave some items as unchecked or add:

***“Only pertinent routine tests were done.”***

At a minimum, efforts should be made to make this cookie cutter style examination be somewhat focused on the real or most significant clinical realities.

Always end with a strong inclusive global statement of things which are always part of your routine:

***“Diagnosis and pertinent options, tests and risks were explained as the plan of care was discussed. The patient expressed understanding and agrees with the plan of care after all questions were answered. Patient also understands to call or return if any new concerns arise.”***

### **A Last Practical Warning**

Inflexible protocols or prerequisites are now being embedded in many EMR systems. Software may now generate unnecessary orders or automatically prevent care from being delivered until other less expensive treatment is done. Systems like this are sometimes controlled by individuals without medical training and may needlessly burden or limit practitioners. The non-medical designers may be more interested compliance with governmental regulations or satisfying the directives imposed by the Joint Commission, insurers or other bureaucracies than treating unique patients. Health care providers should recognize and ask why these efforts are being made. In the future, it may become necessary for physicians to respectfully, but fervently, resist efforts to prevent delivery of care on moral and ethical grounds.

[<<Prev Rule](#)[Next Rule>>](#)

# Texas Administrative Code

TITLE 22

EXAMINING BOARDS

PART 9

TEXAS MEDICAL BOARD

CHAPTER 165

MEDICAL RECORDS

RULE §165.1

Medical Records

(a) Contents of Medical Record. Regardless of the medium utilized, each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an "adequate medical record" should meet the following standards:

(1) The documentation of each patient encounter should include:

(A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;

(B) an assessment, clinical impression, or diagnosis;

(C) plan for care (including discharge plan if appropriate); and

(D) the date and legible identity of the observer.

(2) Past and present diagnoses should be accessible to the treating and/or consulting physician.

(3) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.

(4) The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance should be documented.

(5) Relevant risk factors should be identified.

(6) The written plan for care should include when appropriate:

(A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;

(B) any referrals and consultations;

(C) patient/family education; and,

(D) specific instructions for follow up.

(7) Include any written consents for treatment or surgery requested from the patient/family by the physician.

(8) Include a summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.

(9) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.

(10) All non-biographical populated fields, contained in a patient's electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations,

diagnostics or assessments as documented by the physician.

(11) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.

(12) Salient records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.

(13) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient's status. Paragraphs (1) - (12) of this subsection may be modified to account for these variable circumstances in providing medical care.

(b) Maintenance of Medical Records.

(1) A licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of the date of last treatment by the physician.

(2) If a patient was younger than 18 years of age when last treated by the physician, the medical records of the patient shall be maintained by the physician until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer.

(3) A physician may destroy medical records that relate to any civil, criminal or administrative proceeding only if the physician knows the proceeding has been finally resolved.

(4) Physicians shall retain medical records for such longer length of time than that imposed herein when mandated by other federal or state statute or regulation.

(5) Physicians may transfer ownership of records to another licensed physician or group of physicians only if the physician provides notice consistent with §165.5 of this chapter (relating to Transfer and Disposal of Medical Records) and the physician who assumes ownership of the records maintains the records consistent with this chapter.

(6) Medical records may be owned by a physician's employer, to include group practices, professional associations, and non-profit health organizations, provided records are maintained by these entities consistent with this chapter.

(7) Destruction of medical records shall be done in a manner that ensures continued confidentiality.

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**Source Note:** The provisions of this §165.1 adopted to be effective December 29, 1997, 22 TexReg 12490; amended to be effective September 14, 2003, 28 TexReg 7703; amended to be effective March 4, 2004, 29 TexReg 1946; amended to be effective September 28, 2006, 31 TexReg 8090; amended to be effective January 20, 2009, 34 TexReg 337; amended to be effective September 19, 2010, 35 TexReg 8350; amended to be effective May 20, 2015, 40 TexReg 2665

[Next Page](#)

[Previous Page](#)

[List of Titles](#)

[Back to List](#)

[HOME](#)

[TEXAS REGISTER](#)

[TEXAS ADMINISTRATIVE CODE](#)

[OPEN MEETINGS](#)

[<<Prev Rule](#)[Next Rule>>](#)

# Texas Administrative Code

TITLE 22

## EXAMINING BOARDS

PART 11

## TEXAS BOARD OF NURSING

CHAPTER 217

## LICENSURE, PEER ASSISTANCE AND PRACTICE

## RULE §217.11

## Standards of Nursing Practice

The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted.

(I) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:

(A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;

(B) Implement measures to promote a safe environment for clients and others;

(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same;

(D) Accurately and completely report and document:

(i) the client's status including signs and symptoms;

(ii) nursing care rendered;

(iii) physician, dentist or podiatrist orders;

(iv) administration of medications and treatments;

(v) client response(s); and

(vi) contacts with other health care team members concerning significant events regarding client's status;

(E) Respect the client's right to privacy by protecting confidential information unless required or allowed by law to disclose the information;

(F) Promote and participate in education and counseling to a client(s) and, where applicable, the family/significant other(s) based on health needs;

(G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices;

(H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations;

(I) Notify the appropriate supervisor when leaving a nursing assignment;

(J) Know, recognize, and maintain professional boundaries of the nurse-client relationship;

(K) Comply with mandatory reporting requirements of Texas Occupations Code Chapter 301 (Nursing Practice Act), Subchapter I, which include reporting a nurse:

(i) who violates the Nursing Practice Act or a board rule and contributed to the death or serious injury of a patient;

(ii) whose conduct causes a person to suspect that the nurse's practice is impaired by chemical dependency or drug or alcohol abuse;

(iii) whose actions constitute abuse, exploitation, fraud, or a violation of professional boundaries; or

(iv) whose actions indicate that the nurse lacks knowledge, skill, judgment, or conscientiousness to such an extent that the nurse's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior.

(v) except for minor incidents (Texas Occupations Code §§301.401(2), 301.419, 22 TAC §217.16), peer review (Texas Occupations Code §§301.403, 303.007, 22 TAC §217.19), or peer assistance if no practice violation (Texas Occupations Code §301.410) as stated in the Nursing Practice Act and Board rules (22 TAC Chapter 217).

(L) Provide, without discrimination, nursing services regardless of the age, disability, economic status, gender, national origin, race, religion, health problems, or sexual orientation of the client served;

(M) Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;

(N) Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment;

(O) Implement measures to prevent exposure to infectious pathogens and communicable conditions;

(P) Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care;

(Q) Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care;

(R) Be responsible for one's own continuing competence in nursing practice and individual professional growth;

(S) Make assignments to others that take into consideration client safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made;

(T) Accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability;

(U) Supervise nursing care provided by others for whom the nurse is professionally responsible; and

(V) Ensure the verification of current Texas licensure or other Compact State licensure privilege and credentials of personnel for whom the nurse is administratively responsible, when acting in the role of nurse

administrator.

(2) Standards Specific to Vocational Nurses. The licensed vocational nurse practice is a directed scope of nursing practice under the supervision of a registered nurse, advanced practice registered nurse, physician's assistant, physician, podiatrist, or dentist. Supervision is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity. The licensed vocational nurse shall assist in the determination of predictable healthcare needs of clients within healthcare settings and:

(A) Shall utilize a systematic approach to provide individualized, goal-directed nursing care by:

(i) collecting data and performing focused nursing assessments;

(ii) participating in the planning of nursing care needs for clients;

(iii) participating in the development and modification of the comprehensive nursing care plan for assigned clients;

(iv) implementing appropriate aspects of care within the LVN's scope of practice; and

(v) assisting in the evaluation of the client's responses to nursing interventions and the identification of client needs;

(B) Shall assign specific tasks, activities and functions to unlicensed personnel commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made and shall maintain appropriate supervision of unlicensed personnel.

(C) May perform other acts that require education and training as prescribed by board rules and policies, commensurate with the licensed vocational nurse's experience, continuing education, and demonstrated licensed vocational nurse competencies.

(3) Standards Specific to Registered Nurses. The registered nurse shall assist in the determination of healthcare needs of clients and shall:

(A) Utilize a systematic approach to provide individualized, goal-directed, nursing care by:

(i) performing comprehensive nursing assessments regarding the health status of the client;

(ii) making nursing diagnoses that serve as the basis for the strategy of care;

(iii) developing a plan of care based on the assessment and nursing diagnosis;

(iv) implementing nursing care; and

(v) evaluating the client's responses to nursing interventions;

(B) Delegate tasks to unlicensed personnel in compliance with Chapter 224 of this title, relating to clients with acute conditions or in acute care environments, and Chapter 225 of this title, relating to independent living environments for clients with stable and predictable conditions.

(4) Standards Specific to Registered Nurses with Advanced Practice Authorization. Standards for a specific role and specialty of advanced practice nurse supersede standards for registered nurses where conflict between the standards, if any, exist. In addition to paragraphs (1) and (3) of this subsection, a registered nurse who holds authorization to practice as an advanced practice nurse (APN) shall:

(A) Practice in an advanced nursing practice role and specialty in accordance with authorization granted under Board Rule Chapter 221 of this title (relating to practicing in an APN role; 22 TAC Chapter 221) and

standards set out in that chapter.

(B) Prescribe medications in accordance with prescriptive authority granted under Board Rule Chapter 222 of this title (relating to APNs prescribing; 22 TAC Chapter 222) and standards set out in that chapter and in compliance with state and federal laws and regulations relating to prescription of dangerous drugs and controlled substances.

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**Source Note:** The provisions of this §217.11 adopted to be effective September 28, 2004, 29 TexReg 9192; amended to be effective November 15, 2007, 32 TexReg 8165

[Next Page](#)

[Previous Page](#)

[List of Titles](#)

[Back to List](#)

[HOME](#)

[TEXAS REGISTER](#)

[TEXAS ADMINISTRATIVE CODE](#)

[OPEN MEETINGS](#)