Legal Implications of Medical Records and FCE Documentation
Your FCE is more than a medical record, it is a legal record

Medical records serve as communication between health care providers regarding the patient's health history, injuries, illness, care plans, response to treatment, tests results and much more. In addition to providing records that manage and document the patient's care, medical records are used in reimbursement, research, and legal issues.

Because the medical record is a legal document, many rules and regulations apply, including regulations on documentation, record retention, privacy acts, and disclosure.

Medical Record: The legal health record has become more complex in the age of electronic documentation. From a health care perspective the medical record includes: history, physical exam, plan of care, orders (verbal, telephone, written orders), documentation of each patient care interaction, progress notes, test results, photographs, videos, graphic records, patient education records, even post-it notes between patient-provider or provider-provider, documentation from telephone conversations and any other interaction that is related to the patient's care. The American Health Information Management Association provides a document titled: Update: Guidelines for Defining the Legal Health Record for Disclosure Purposes.

Documentation Guidelines: Because the medical record is a legal document, legal requirements have been incorporated into how documentation is taught to health care providers. A review from documentation 101:

- All records must reflect the patient name and include identifying information
- Each entry must have date / time / health care provider's signature and designation
- Documentation is required for every patient-provider encounter
- Handwritten documentation must be done in indelible ink
- Errors are corrected by drawing a single line through the error and initialing and dating the error to clearly identify the correction

In addition to the how we document, there are guidelines regarding content of records that are not covered in this article. APTA provides guidelines for Physical Therapy documentation, including content for records. Many healthcare facilities also have standards regarding documentation, such as what must be included in a telephone order.

Legal Implications: Medical records are used in legal proceedings for a variety of purposes including medical malpractice, workers' compensation cases, product liability, civil lawsuits to name just a few. Without the original patient record, a health care provider is left to memory. Remember, if you didn't document it, it didn't happen. The law requires "best evidence" be used at trial and this requires the original written records. Photocopied records are not admissible because of the potential for manipulations.

In an FCE the original report includes the data sheets with patient history, physical exam, observations, and results for each sub-test. Your word-processed FCE report is also part of the original record, but since your conclusions for that report are obtained from your data sheets, those records are important in a court of law. If you summarize your history and physical exam in the FCE summary, it is important that you keep all of your notes in the medical record. Records that are lost or destroyed due to intentional acts or negligence could cause legal claims against you as the healthcare provider.

Medical Record Retention: Each state has regulations related to the retention of medical records.

As a baseline, most facilities must follow the Medicare Condition of Participation Guidelines under

42 CFR 482.24(b). This requires hospitals to retain medical records in their original form for a period of 5 years. In states where there are no specific regulations, it is recommended that records be retained indefinitely; if that is not possible, then retain for a minimum of 10 years after the last contact, but preferably 25 years.

Other considerations in record-keeping requirements:

- The length of time that a claimant has to bring a lawsuit of negligence against professionals (this may vary state by state) often times for minors it is up until they turn 21.
- OSHA requires employers to keep medical records for 30 years on employees exposed to toxic substances or harmful agents.
- Health and Humans Services regulations: must comply with Code of Federal Regulations standard of 5 years.
- Health and Human Services: for facilities certified as a comprehensive outpatient rehabilitation facility (CORF), they must maintain records for 5 years after the patient is discharged.

Summary:
The handwritten notes made during an FCE are part of the legal medical record. Any notes regarding the patient, including referral forms, phone conversations, data sheets and the FCE summary are part of the medical record and can be subpoenaed in a legal proceeding. It is important that you know your state's documentation regulations and follow professional guidelines for documentation, including content. The WorkWell FCE has been standardized to meet all of the requirements for content. If you use the standardized forms provided and keep your handwritten documents, you have everything you need. If you have customized your report, make sure the content of your report is complete. There are federal and state regulations, not only regarding how long you must maintain medical records, but also regulating release of medical records, handling of records if you should close your practice and destruction of medical records. Know the state and federal regulations that are applicable to your facility.

Reference Websites:
http://library.ahima.org/xpedio/groups/public/documents/ahima
http://www.access.gpo.gov/nara/cfr/cfr-table-search.html
http://firstgovsearch.gov/
http://www.hippadvisory.com/regs/recordretention.htm
http://www.apta.org