UC Riverside, School of Medicine Policies and Procedures
Policy Title: Legal Medical Record
Policy Number: 950-02-030

Responsible Officer:	Chief Compliance and Privacy Officer
Responsible Office:	Compliance Advisory Services
Origination Date:	4/2021
Date of Revision:	
Scope:	UCR Health

I. Policy Summary

To define what constitutes a Legal Medical Record for patients receiving evaluation or treatment at UCR Health in accordance with federal and state laws and regulations.

II. Definitions

Legal Medical Record: The collection of information concerning a patient and their health care that is created and maintained in the regular course of UCR Health business in accordance with UCR Health policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation. The source system for this information is Epic. The specific content of the Legal Medical Record is defined in Appendix A.

Epic: UCR Health's electronic medical record inclusive of all systems that contribute to the medical record.

Designated Record Set: A group of records maintained by or for UCR Health that comprises of:
(1) Medical and billing records about an individual patient,
(2) Enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or
(3) Information used in whole or in part by or for UCR health to make decisions about an individual patient. The specific content and exclusions of the Designated Record Set are defined in Appendix A.

III. Policy Text

It is the policy of UCR Health to maintain a medical record for every individual who is evaluated or treated at a UCR Health clinical practice sites. The medical record contains adequate information to identify the patient, support the diagnosis, justify the treatment, describe the patient's progress and response to medications and services, and promote continuity of care among health care providers.

IV. Responsibilities

Health Information Management Services
Compliance Advisory Services

V. Procedures

A. Confidentiality: The medical record is confidential and is protected from unauthorized disclosure by law under HIPAA, HITECH and California law. The circumstances under which UCR Health may use and disclose confidential Medical Record information are set forth in the UCR Notice of Privacy Practices and in UCR SOM Policy 950-02-009 "Access, Use and Disclosure of Protected Health Information."

B. Medical record content shall meet all state and federal legal and regulatory requirements.

C. Appendix A contains a listing of required Legal Medical Record documentation content.

D. To the extent that is reasonable, UCR Health uses standardized formats to document the care, treatment and services provided to patients.

E. All medical records must comply with the applicable UCR Health requirements for content, timely completion, and authentication, including timely completion of history and physical examinations, and procedure documentation.

F. The Designated Record Set as defined in Appendix A is provided the same level of confidentiality as the Legal Medical Record is included in the data which comprises the Designated Record Set.

G. UCR Health employees may document in the medical record. The categories of persons authorized to document in the medical record are defined in Appendix B.

H. Ownership and Maintenance of Medical Records

1. All medical records of UCR Health patients, regardless of whether they are created at or received by UCR Health, and patient billing information, are the property of UCR Health.
2. Records will be produced in compliance with state and federal law when requested by a patient or authorized representative or in response to a subpoena.
3. If an employed physician or provider leaves or is terminated by the UCR Health for any reason, they may not remove any original medical records, patient lists, and/or billing information from UCR Health facilities and/or offices.

I. Retention and Destruction of Medical Records (See UCR SOM "Records Retention Policy" (950-02-023).

J. Legibility and Authentication of Medical Records:

1. All medical record entries must be legible and complete, dated and timed promptly by the person who is responsible for providing or evaluating the service furnished.
2. The author of each medical record entry is identified in the medical record and includes the author's licensure/credentials designation or job title.

K. Patients may request to make amendments or addendums to their medical record as defined in the UCR Notice of Privacy practices.

VI. Related Information

Confidentiality of Medical Information Act (CMIA) [California Civil Code Section 56, et seq.]

Health Insurance and Portability Act (HIPAA) [Title 45 Code of Federal Regulations Part 160, 162 and 164]

Health Information Technology for Economic and Clinical Health (HITECH) Act [Title XIII, Division A, ARRA]

VII. Revision History

N/A

Approvals:

COMPLIANCE COMMITTEE (12/10/2021)

Paul Hackman Digitally signed by Paul Hackman Date: 2021.12.15 11:07:56 -08'00' — 12/15/2021

PAUL HACKMAN, J.D., L.LM.
CHIEF COMPLIANCE AND PRIVACY OFFICER,
SCHOOL OF MEDICINE — DATE

Deborah Deas Digitally signed by Deborah Deas Date: 2021.12.21 08:49:20 -08'00' — 12/21/2021

DEBORAH DEAS, M.D., M.P.H
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Appendix A:

L. Contents of Legal Medical Record

- Advance directives
- After Visit Summary
- Allergy records
- Alerts and reminders
- Authorization forms for release of information
- Clinic notes, including dates and times of visits
- Consent forms
- Consultation reports
- Correspondence to and from patient
- Departure time
- Diagnostic reports
- Encounter Documentation
- Fetal monitoring reports
- Functional status assessments
- Graphic and vital sign records
- History and physical examination records
- Identification information, if available:
    - Name
    - Address
    - Telephone number
    - Email address
    - Identification number
    - Medicare/Medi-Cal
    - Medical Record Number
    - Age
    - Sex
    - Marital status
    - Place of birth
    - School grade, if applicable
    - Language preference
    - Name, address and telephone number of emergency contact
- Immunization records
- Laboratory test results
- Medication administration records, including adverse drug reactions
- Medication orders
- Medication profiles
- Neonatal history for pediatric patients
- Notice of Privacy Practices acknowledgments
- Operative and procedure reports

- Orders including diagnostic tests for laboratory and radiology, medication
- Patient education, documentation of
- Prescriptions written
- Pathology test results/reports
- Problem list
- Progress notes and documentation
- Psychology and psychiatric assessments and summaries
- Radiology test results
- Referral information and clinical data from other providers if they are used whole or in part by UCR Health for care and treatment
- Research records to the extent they are maintained in the Medical Record
- Screening tests
- Telephone orders
- Verbal orders

II. Designated Record Set

To the extent that the following patient information is created and/or maintained by UCR Health, the contents of the Designated Record Set include:

- Contents of Legal Medical Record (see Above)
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding
- Psychotherapy notes
- Patient identifiable source data:
  - Audio files of dictation
  - Audio files of patient telephone calls
  - Telephone consultation audio files
  - Videos of office visits, procedures or telemedicine consultations
  - Diagnostic films and other diagnostic images from which interpretations are derived
  - Electrocardiogram tracings from which interpretations are derived
  - Fetal monitoring strips from which interpretations are derived
  - Wave forms such as ECGs and EMGs from which interpretations are derived

Designated Record Set does not include:

- Appointment or surgical schedules
- Back-up information used in the billing and insurance authorization processes.
- Information used solely for health care operations, such as:
  - Quality assessment and improvement activities, including case management and care coordination
  - Competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation
  - Conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs

- Specified insurance functions, such as underwriting, risk rating and reinsuring risk
- Business planning, development, management and administration
- Business management and general administrative activities of the entity, including but not limited to: de-identifying PHI, creating a limited data set and certain fundraising for the benefit of UCR Health working or teaching notes
- Peer review information protected by California Evidence Code section 1157 or other confidential or privileged information
- Oral communication dealing with treatment, payment or operations
- Photographs for identification purposes (digital and analog)
- External records provided by patient or external health care provider, that are not used nor maintained by or for UCR Health
- Requisitions for labs, pathology or radiology
- Information derived from Epic's Share Everywhere Function
- Data collected and maintained for research to the extent it is maintained outside the patient's Medical Record
- Administrative Data and Documents (patient-identifiable data used for administrative, regulatory, healthcare operations, and payment (financial) purposes, including but not limited to:
    - Abbreviation and do-not-use abbreviation lists
    - Analog and digital photographs for identification purposes only
    - Audit trails and metadata
    - Communication tools
    - Correspondence concerning requests for records
    - Databases containing patient information
    - Event history and audit trails
    - Financial, billing and insurance forms
    - Incident or patient safety reports
    - Logs
    - Patient-identifiable claims
    - Patient-identifiable data reviewed for quality assurance or utilization management
    - Protocols and clinical pathways, practice guidelines, and other knowledge sources that do not imbed patient data
    - Registries
    - Staff roles and access rights
    - Work lists and works-in-progress
    - Clinical decision support system-generated notifications, prompts or alerts
    - Registration Alerts related to patients with certain protocols, behavioral history Clinical decision support system-generated notifications, prompts or alerts (associated documentation is part of LHR) e.g., Provider is alerted to perform a diabetic foot exam on a diabetic patient. The alert is not part of LHR, the action as documented in.

- Registration Alerts related to patients with certain protocols, behavioral history

Appendix B: Persons Authorized to Document in the Medical Record

- Fellows
- Interns
- Licensed Vocational Nurses
- Medical Assistants
- Mental Health Practitioners
- Nurse Practitioners
- Pharmacists
- Physician Assistants
- Physicians including MD's and DO's
- Psychologists
- Registered Nurses
- Residents
- Respiratory Therapists
- Students, MD (notations in the record must be cosigned by supervising clinician)
- Others as designated by UCR Health Policies and/or Bylaws