APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 420 Department or Agency Alabama Department of Public Health

Rule Number 420-5-7-.13
Rule Title Medical Record Services

_____ New X Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare or safety?	No
Is there a reasonable relationship between the state's police power and the protection of the public health, safety or welfare?	Yes
Is there another, less restrictive method of regulation available that could adequately protect the public?	No
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	No
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	n/a
Are all facts of the rulemaking process designed solely for the purpose of and so they have as their primary effect, the protection of the public?	Yes
Does the proposed rule have an economic impact?	No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of §41-22-23, Code of Alabama, 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama, 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of Certifying Officer Patricia Shine Date 5/17/2013

FORM APA2
11/96

STATE BOARD OF HEALTH
NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Department of Public Health

RULE NUMBER AND TITLE: 420-5-7-.13 Medical Record Services

INTENDED ACTION: Amendment to Rule number 420-5-7-.13

SUBSTANCE OF PROPOSED ACTION: To modify the state hospital rules bringing them into conformity with recent changes to the federal regulations. This amendment eliminates a lapsed federal requirement that required verbal orders to be authenticated within 48 hours. This change eliminates the need for the waiver approved by the Committee of Public Health in August of 2012.

TIME, PLACE, AND MANNER OF PRESENTING VIEWS: A public hearing will be held on June 11, 2013, at 201 Monroe Street, RSA Tower, Suite 1586, The Board Room, Montgomery, AL 36104, at 2:30 p.m.

FINAL DATE FOR COMMENTS AND COMPLETION OF NOTICE: Written or oral comments will be received until the close of the record at 5:00 p.m. on July 5, 2013. All comments and requests for copies of the proposed rule should be addressed to the contact person listed below.

CONTACT PERSON AT AGENCY: Walter T. Geary, Jr., M.D., Director, Bureau of Health Provider Standards, Department of Public Health, 201 Monroe Street, Suite 710, Montgomery, Alabama 36104, telephone number (334) 206-5366.

Patricia E. Ivie, Agency Secretary

420-5-7-.13 Medical Record Services.

(1) The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual evaluated or treated in the hospital.

(2) Organization and staffing. The organization of the medical record service shall be appropriate to the scope and complexity of the services performed. The hospital shall employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

(3) Form and retention of record. The hospital shall maintain a medical record for each inpatient and outpatient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(a) Medical records shall be retained in their original or legally reproduced form for a period of at least five years. In the case of minor patients, records shall be retained for at least five years after the patient has reached the age of majority.

(b) The hospital shall have a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

(c) The hospital shall have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital shall ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records shall be released by the hospital only in accordance with federal or state laws, court orders, or subpoenas.

(4) Content of record. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(a) All patient medical record entries shall be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

1. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, except as noted below.

2. All orders, including verbal orders, shall be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized to write orders by hospital policy.

3. All verbal orders must be authenticated within ~~48 hours~~ such time period as provided by hospital policy, but no more than 30 days following entry of the order.

(b) All records shall document the following, as appropriate:

1. Evidence of:

a. A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

b. An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination shall be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

2. Admitting diagnosis.

3. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

4. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.

5. Properly executed informed consent forms for procedures and treatments specified by the medical staff.

6. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

7. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

8. Final diagnosis with completion of medical records within 30 days following discharge.

(5) The hospital shall maintain a plan to transfer all records to another facility in the event the hospital ceases operation.

Author: W.T. Geary, Jr., M.D., Carter Sims
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.

History: Filed September 1, 1982. **Repealed and New Rule:** Filed November 18, 1994; effective December 23, 1994. **Amended:** Filed January 19, 1996; effective February 23, 1996. **Repealed and New Rule:** Filed August 24, 2012; effective September 28, 2012.

Ed. Note: Rule .10 was renumbered to .13 as per certification filed August 24, 2012; effective September 28, 2012.