Electronic Medical Records (EMR)

As many of you already know, the world is turning digital. Medicine has been keeping up with this revolution with rapid changes in the way we gather, store, archive, retrieve and share information. Most medical offices are moving towards a “paperless” office. Only ten years ago the concept of going paperless was a dream. Today, not only is it possible, but it is fundamental to running a cost effective and efficient office.

The Electronic Medical Record (EMR) is a reality today. Most practices have some form of electronic records. While some offices are just starting by using entry level practice management software, others have full blown EMR programs that generate reports, scan documents, and share information with other providers and hospitals. Radiologists have taken the digital format of many imaging modalities and developed ways for distribution of the images via the internet or CD/DVD. Universal standards are being developed for the format of digital information as demonstrated by the DICOM standards for image storage.

Digital storage of medical records has some unique considerations when it relates to law. Aside from the HIPAA concerns, there are the admissibility concerns when using digitally scanned, stored and archived data in a legal proceeding. Case law seems to vary from state to state but I have done some investigation here in Connecticut and here is what I have found out so far.

I have contacted the council for the Connecticut Chiropractic Association regarding the scanning of medical records and retention requirements. This is their opinion “The same 7 years applies to digital records. A doctor is not required to maintain duplicate records. Once a record is stored in the computer, hard copies may be destroyed. The CT Rules of Evidence allow for the admission of digital records. The attorney may be concerned about the alteration of digital records which is another issue”

On December 6th, 2001, Connecticut Attorney General Richard Blumenthal issued an opinion regarding digital records as it relates to the department of Revenue Services. Specifically as it relates to admissibility he states the following: “The following statutes indicate that as long as the accuracy of the electronic record can be demonstrated, paper records may be converted electronically and used as evidence in contested matters and for other administrative purposes, and once converted accurately, the original paper record may be destroyed”. Section 12-39bb of the Connecticut General Statutes provides: “Records of the Department of Revenue Services may be provided in the form of written documents, reproductions of such documents, films or photo-impresions, or electronically produced tapes, disks or records, or by any other mode or means which the commissioner determines necessary or appropriate. Any reproduction of any return, document or other matter made in accordance with this section shall have the same legal status as the original, and any such reproduction shall, if properly
authenticated, be admissible in evidence in any judicial or administrative proceeding as if it were the original, whether or not the original is in existence. (Emphasis added).

While the above citing is related to DRS, it seems that the statutes in Connecticut recognize the trend and have implemented regulations to accommodate the technological advancement. One can reasonably assume that digital medical records have found their place in the legal system and would likely not be a problematic area in a personal injury proceeding as it relates to admissibility.

I have spoken with others in the legal community regarding digital medical records. While there is still some hesitancy with regard to admissibility, all agree that this is the wave of the future. In fact, many have implemented digital storage solutions into their own law offices so that they can receive the benefit of instant access, decreased space requirements, shorter retrieval times and lower costs.

The Shaw Chiropractic Group has used digital records for quite some time. We still prefer paper charts when we are actively treating but upon patient discharge, we scan and archive the file so that it can be easily retrieved and distributed. We no longer have issues with lost files or incomplete records. Our files are immediately available across the entire enterprise. Upon receiving a properly executed, HIPAA compliant records release, we quickly retrieve and distribute the medical record. For requests with email capabilities, the file can be on their computer in PDF format in literally seconds.