

standards of practice

This document has been created to support Massage Australia Accredited members in maintaining the expectations of our organisation. In conjunction with this document, it is also important to take the time to understand your obligations and the organisations' rules relating to the Massage Australia Code of Conduct and its complaints process. This information can be found on our website.

Note: Accredited member refers to Professional Plus members that are registered as health fund providers through Massage Australia.

management of client/patient records

The following standards relate to the professional, legal and clinical requirements for keeping adequate client/patient records. This document should be read in conjunction with relevant provisions of the Commonwealth Privacy Act 1988 and State Privacy and Health Records Act.

principles

- Standards in this section relate to 'accredited' member practices in all settings.
- For professional and legal reasons an 'accredited' member is required to keep and maintain adequate client/patient records, which clearly reflect the course of client/patient management. As records are usually the only tangible evidence of examinations, findings and the care provided.
- Relevant clinical findings, both positive and negative, should be recorded.
- Record keeping styles may vary from practitioner to practitioner.
- The health care record contains confidential information, which as a matter of law, should not be released, except on the express consent of the client/patient or pursuant to a court order, a health fund direction or otherwise as compelled by law.
- The taking and recording of informed consent is an important aspect of record keeping.
- Taking of notes whilst the client/patient gives their history. Reporting it from memory later is less detailed and accurate.
- The general quality and content of client/patient records must address any safety issues and be a comprehensive and accurate record.

the importance of adequate records

Massage Australia 'accredited' practitioners are required to meet terms and conditions provided by each health fund, relating to the recognition of providers for services to their members. For the purposes of this standard, attention is drawn to the requirements of receipting, invoicing, management and maintenance of client/patient records. Adherence to the requirements of the standards of record keeping offers protection in the event of a health fund audit of your records, including treatment plans and the care of the health fund member (your client/patient).

This audit may be conducted directly between you and the health fund that you are registered with, or between Massage Australia and the 'accredited' member. Massage Australia is required under health fund registration rules, that as a professional organisation we are to conduct a predetermined number of audits on our own members each year.

If your standard of record keeping is found to be lacking, the health fund may revoke your provider number(s) and you will no longer be registered with that health fund. Adherence to the requirements of the standards of record keeping offers protection in the event of a complaint being laid against you or the treatment you have provided. Please refer to the Massage Australia Code of Conduct for conduct details.

guidelines for record keeping

Accounting records

Massage Australia accredited members have a professional and legal responsibility to maintain accurate, legible contemporaneous account records of each visit. As a minimum, each account record must be labelled with the client/patient's identifying details and:

- The date of each consultation;
- Itemised fees charged; and
- Details of payments including the date of the payment.

Note: This can be achieved by using a duplicate receipt book.

An itemised receipt must be issued for each payment, indicating:

- The date of payment,
- Name of the practitioner who provided the service,
- Clinic location (street address only, no PO Box),
- Contact telephone number (this can be a mobile number),
- Name of the client/patient who received the treatment,
- Date of consultation,
- Association Number (e.g. MA2345),
- Provider number for which the client/patient is claiming from (this will be the individual provider number issued to you by Massage Australia or the health fund and will be different to your MA membership number),
- Treatment provided (e.g. Remedial Massage), and
- Charge(s) (amount paid).

Electronic Records

Electronically held records must meet the same requirements as non-electronically held records with the following additional considerations:

- Records should be password protected to ensure that only the MA accredited member and authorised support staff can access the records.
- Protective pass-codes should be used and updated on a regular basis including when a staff member ceases employment.
- Client/patient records should not be sent by email unless there is protection, such as encryption, from potential unauthorised access.
- No individual should be permitted to access or use the practice computer(s) other than authorised staff members.
- Client/patient access to their records held on computer can be provided via a direct printout of the record, upon verification of client identity.
- Adequate secured backup systems to protect client/patient records are essential and must provide a guarantee of the ability to restore up-to-date information in the event of power loss or system or computer failure.

Responsibilities

- Massage Australia members have a professional and legal responsibility to:
- Keep confidential the information they collect and record about clients/patients.

- Retain, transfer, dispose of, correct and provide access to clinical records in accordance with the requirements of the laws of the relevant states, territories and the commonwealth, as well as in accordance with Private Health Fund Provider terms and conditions.
- Practitioners must be familiar with the requirements of the Privacy Act 1988 as well as their state or territory privacy and health records legislation, including the provisions that govern the retention of health records (retention for seven years) and the retention of records relating to children and youth under 16 years of age.
- Third party access is subject to the provisions of the relevant privacy and health records legislation and terms and conditions relating to provision of treatment for their members.
- Assist clients/patients to make well-informed decisions about their treatment.
- Refrain from committing acts of fraud and if you suspect that a person or group is engaged in fraud, report this directly to the health fund (Note: refer to common types of fraud below for more information)
- Retain client/patient records for a minimum period of 7 years, and where the client/patient is under 21 years of age, for a period of 7 years after he or she would have reached 21 years of age.
- Clinical records must be legible and understandable and of such quality that another treating practitioner could read and understand the terminology and abbreviations used.
- Client/patient records are to be maintained in English or must be translated to English (responsibility of the provider) if required for an audit. [see 'Records not in English']
- Client/patient records relating to claims must be made available on request for audit purposes. (Refer to the Audit of Provider's Records on how this information is shared)

audit of provider's records

Health funds conduct regular reviews of their claims database in order to determine the treatment patterns of individual providers as well as groups of providers.

On some occasions during these reviews, it is necessary to seek further information from providers in regard to particular claims or their treatment profiles. These requests are usually made in writing and it is a condition of registration as a provider that you comply with these requests and cooperate with the health funds. Failure to comply with such requests, which may involve sending a full copy of the client/patient records, may result in health funds taking further action.

During a review, health funds may, depending on the nature of the review, contact their health fund members'. The health care provider (you) may not always be contacted prior to such an approach to the health fund member.

All providers are considered responsible for any actions by staff members or others, who may have authority to access client/patient files. All providers are considered responsible for keeping safe their client/patient records.

Note: If a random audit does take place, client information should be excluded i.e. name, address telephone number.

intake/progress forms

Intake forms

The following information is necessary as part of the intake form/initial clinical record and is to be recorded and maintained, where relevant:

For every initial consultation, clear documentation of information relevant to that consultation should be included in the intake form as follows:

- Identifying details of the client/patient, including name, contact details, gender and date of birth (and client/patient's parent or guardian where applicable).
- Current health history and relevant past health history, including known past treatment by other health professionals.

- Reason for visit; presenting symptoms; current or past injuries or medical treatments; current medication taken.
- Relevant family health-related history.
- Contact details of the person the client/patient wishes to be contacted in an emergency (not necessarily next of kin).
- Current general practitioner.
- The client/patient must sign their initial intake form, after consultation of their treatment plan.

Progress Notes

The level of detail required in client/patient records may vary according to the nature of the presenting condition and whether it is an initial or subsequent consultation. For example, in the case of subsequent visits for an ongoing condition, information recorded in earlier consultations need not be repeated, unless there are relevant changes. Progress details for the treatment must however be recorded clearly and include the following:

- The date of the consultation
- The name of the practitioner who conducted the consultation, including the signature where applicable
- Information about the type of assessments conducted
- Relevant clinical findings and observations etc
- All procedures conducted including details of all soft tissue applications
- Details of advice provided
- Recommended management plan and, where appropriate, expected process of review
- Details of how the client/patient was monitored and the outcome (progress notes)
- Any unusual sequel of treatment or adverse events

records not in english

Massage Australia recognises the cultural diversity of its members and the cultural diversity of their clients/patients.

For the purposes of client/patient safety and clear communication between client/patient and practitioner, it may be necessary to record information in the language of the practitioner and the client/patient.

The requirement of legislation and adherence to health fund terms and conditions is that all client/patient records are to be recorded in English.

Where records are maintained in a language other than English, should a copy of a client/patient's records be requested by the client/patient, or required by an authorised third party, it is the responsibility of the 'accredited' member's practitioner to provide at their own expense an English translation of the client/patient's records.

requests for reports or records

'Accredited' members have a professional and legal responsibility to provide access to and or copies of records relevant to the client/patient:

- Upon request by the client/patient
- Upon request by a health fund direction
- Upon request by a court order or otherwise as compelled by law
- Upon request by the association (i.e. random audit requirements)

Common Types of Fraud

Experience has shown that providers and health fund members are not always aware of what constitutes fraud or inappropriate claiming (whilst this still does not excuse their obligation to know what is fraudulent).

In relation to claiming benefits, fraudulent or inappropriate behaviour is defined as the member or provider, individual or in collusion, knowingly or recklessly giving, supplying or providing information, whether written, electronic or verbal, that is intended or likely to mislead a Health Fund into paying a level of benefit to (or on behalf of) the member, to which they would otherwise not be entitled.

Misleading information on accounts/receipts may include:

- Treatment not actually provided
- Incorrect itemisation/description of treatment
- Incorrect dates the services were completed
- Incorrect client/patient name
- A fee for a service that was not what the client/patient was actually charged e.g. the client/patient was charged less than the fee documented on the account, however the 'discount' given to the patient was not disclosed on the account
- Incorrect provider identification
- (All health care providers have a responsibility to ensure that all documentation, including clinical records and accounts, are maintained in a true and accurate manner)

Requirements of the Association relating to fraudulent activity

- Provide ongoing education to members concerning the use, and consequences of fraud and misuse of Individual Provider Numbers (IPNs)
- Encouraging members to report on IPN fraud or misuse

Appendix A

Practitioner – Client Record Self-Evaluation

The following list can be used for self-evaluation for your client/patient records to identify strengths and weaknesses in record-keeping practices and documentation.

Client Record keeping Activity	Yes	No	Action Required
My record keeping system allows for ready retrieval of an individual patient file.			
My records are legible			
My abbreviation Legend is available and is the abbreviation Legend commonly used by all health professionals			
My Records are written in English			
My Records are written in another language other than English but also with English translation			
The client/patient's identity is clearly evident on each component of the file			
A signed Consent for Treatment Form forms part of the record			
Each client/patient file clearly shows full name, address, date of birth, gender			
The date of each consultation is recorded			
The family history, functional inquiry & past history (including significant negative observations) is recorded and maintained			
Allergies are clearly documented			
An updated list of current medications (including 'over the counter' vitamins and herbal preparations) is recorded in the file			
Lifestyle factors such as smoking, special diets, exercise, alcohol consumption and recreational drugs are recorded			
A 'cumulative client profile' relating to each client is present and fully maintained			
The 'presenting condition' (primary complaint) is clearly stated			
The duration of symptoms is noted			
An adequate description of the symptoms is present			
Positive physical findings are recorded			
Significant negative physical findings are recorded			
Records of external laboratory tests and other investigations are included with the client/patient records			
A signed 'consent to release confidential Information' is evident in the case of a need for referral			
All letters of referral are maintained within the record			
Requests from the client/patient for consultation with other health care practitioners are documented			
The assessment of signs and symptoms is recorded			
The treatment plan and/or treatment is recorded			
Doses (number of required treatments) and duration (length of each treatment) of prescribed remedies are noted			
Progress notes relating to the management of clients suffering from chronic conditions are made			

There is documented evidence that periodic general assessments are being made			
There is evidence that adjustments to the Treatment Plan are being made to match the progress of the periodic general assessments			
There is documented evidence that health maintenance is periodically discussed (topics such as exercise, lifestyle changes etc)			
There is evidence that the practitioner periodically reviews the list of prescribed drugs, supplements, remedies etc. being taken by client/patients suffering from multiple or chronic conditions			
In the event that more than one practitioner is making entries in the client file, is it evident that each practitioner is identifiable?			
Information about possible negative outcomes of treatment given to the client/patient is recorded			
Evidence of client/patient non-compliance with practitioner recommendations and the course of action taken to assist the client/patient to become compliant is maintained in the records			
Documented evidence of specific activity given to the client/patient to carry out between visits is maintained in the records			
Phone conversations and any home visits are documented in the client/patients records			
If a transfer of client records is requested all written requests, fees charged and obligations are recorded in the records			
Notes:			