

### **III. MEDICAL RECORDS AND MEDICAL RECORD REVIEWS**

Each provider office and Medical Facility will maintain complete medical records for each Plan member according to accepted professional practice standards, as well as state requirements. The Provider's medical records must be available for Utilization and Quality Management Review studies and customer service inquiries conducted by Neighborhood Health Partnership. Section § 164.506 of the Health Insurance Protection and Portability Act (HIPAA) indicates that the routine form you obtain is sufficient for disclosures to carry out health care operations. Section § 164.506 defines health care operations to include quality assessment and improvement activities such as medical record reviews.

Neighborhood Health Partnership Providers must assure that medical records and all patient information are maintained in a manner that protects the confidentiality of the patient, are not accessible to the general public and are in compliance with all federal and state statutes including but not limited to the HIPAA. This must also permit the prompt retrieval of legible and timely information, accurately documented and readily available to appropriate or authorized health care practitioners.

Medical record documentation is the focus of health care communication and continuity of care. Therefore, the record is the primary assessment resource of the Quality Management Program in every location in which patient care services are provided. Neighborhood Health Partnership has adopted the following guidelines for the effective documentation of patient/provider medical care. Medical records will be regularly and systematically reviewed and audited on site for contents, format, and timely completion of all significant clinical information pertaining to a Plan member. NHP has established a goal of 95% compliance with all elements of medical record requirements. Any practitioner whose medical record review results in a score lower than 95% may be subject to a re-review to assess the effectiveness of corrective action.

An adequate medical record must be maintained for every individual who is evaluated or treated. The following guidelines reflect minimum content requirements only. These guidelines do not replace or otherwise supplement documentation, which may be required, in the professional judgment of the provider, to ensure that proper medical care is rendered to the member.

#### **IV. MEDICAL RECORD DOCUMENTATION GUIDELINES FOR PRIMARY CARE PHYSICIANS**

- An individual record for each member.
- Identification of the patient's Primary Care Physician.
- A record of each visit is made which reasonably reflects the condition/symptoms of the member, any treatment or drugs dispensed (including dosage, frequency and duration) and such other information as may be necessary to accurately reflect the visit and comply with applicable law.
- Each page in the record should contain patient's identification.
- Biographical/Personal data – Name, sex, DOB, address, employer, home and work telephone numbers, and marital status should be recorded on the Medical Record. This information should be updated as necessary.
- All entries including dictations should be identified as to author. This includes nurses or office personnel, as well as physicians. The profession of the practitioner (i.e., M.D., RN, etc.) should be included with initials or signature.
- All entries should be dated and signed.
- The record should be legible to the reviewer and written in English.
- Problem List – Significant illnesses and medical conditions should be indicated on the problem list. If the patient has no known medical illness or conditions, the chart must include a flow sheet for health maintenance. There may be a separate list or listed clearly and identified as a problem list at each visit.
- Medication List - A profile of all ongoing or long-term medications, including dosage, frequency and duration, should be present. There may be a separate list or listed clearly and identified as a medication list at each visit.
- Allergies – Medication allergies and adverse reactions should be prominently noted in a visible and consistent place in the record.
- Past medical history – (for the patient seen 3 or more times). Past medical history should be easily identified including serious accidents, operations, and illness. For children, past medical history will be related to prenatal care, birth information, surgery, and childhood illness.

- Smoking/ETOH/Substance Abuse – Notation concerning cigarettes and alcohol use and substance abuse should be present. (For patients 14 years and over and seen 3 or more times). Abbreviations and symbols may be appropriate. Patients should be encouraged to attend appropriate cessation programs as necessary.
- History and Physical – Appropriate subjective and objective information is obtained for the presenting complaints.
- The record should reflect the appropriate use of laboratory testing and other studies.
- The record should reflect the working Diagnosis(es), and Plan/Treatment.
- Return visit – Encounter forms or notes should have a notation when indicated concerning follow-up care, call or visit. Specific time to return should be noted in weeks, months or PRN.
- Follow-up – Unresolved problems from previous office visits should be addressed in subsequent visits.
- There should be a mechanism in place to document and address “no-shows”.
- Treatment Plan should be documented at each visit.
- The PCP’s records should reflect the appropriate use of consultants. Every referral should have a corresponding report from the Specialist. Specialist should have a copy of the report that they sent to the PCP on the record.
- Documentation of ancillary services received by the patient should be documented in the record.
- The record must demonstrate continuity of care.
- All lab results and diagnostic tests should be signed or initialed by the physician to indicate they were seen. Abnormal results should have an explicit notation about follow-up plans.
- Documentation should support medically appropriate care.
- There should be no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

- Immunization record – For pediatric records (ages 20 and under) there should be a completed immunization record or a notation that “immunizations are up-to-date”. For adult members appropriate history concerning immunizations should be in the record. Documentation should appear that the member has been offered adult immunizations (as per NHP Adult Preventive Guidelines).
- Preventive Services – There should be evidence that preventive screening and services are offered in accordance with Neighborhood Health Partnership, Inc. guidelines.
- Advance Directives – There should be a copy of signed Advance Directive in the medical record of each adult NHP Medicaid and NHP Medicare member. (An Advance Directive is “written instructions for living will or power of attorney”). At a minimum, documentation on whether or not a member has executed an advance directive must be included in a prominent position in the medical record
- Documentation of appropriate general health education, as well as condition specific education should be part of the record.
- The medical record needs to include documentation of emergency care and the hospital discharge summary if the member has received such services.

## V. MEDICAL RECORD DOCUMENTATION GUIDELINES FOR SPECIALISTS

- Each page in the record should contain patient's identification..
- Biographical/Personal data – Name, sex, DOB, address, employer, home and work telephone numbers, and marital status should be recorded on the Medical Record. This information should be updated as necessary.
- All entries including dictations should be identified as to author. This includes nurses or office personnel, as well as physicians. The profession of the practitioner (i.e., M.D., RN, etc.) should be included with initials or signature..
- All entries should be dated and signed.
- The record should be legible to the reviewer and written in English.
- Allergies should be consistently and prominently noted. An allergy sticker on the front of the chart is suggested.
- A clinical history appropriate to the specialty should be in the record. ER visits or medication taken by the patient should be noted if they pertain to the condition for which they are seeing the specialists.
- A working diagnosis should be noted, that is, the problem should be identified and should be consistent with the subjective and objective findings.
- A record of each visit is made which reasonably reflects the condition/symptoms of the member, any treatment or drugs prescribed (including dosage, frequency and duration) and such other information as may be necessary to accurately reflect the visit and comply with applicable law.
- Lab work and other diagnostic studies should be ordered whenever appropriate.
- All lab results and diagnostic tests should be signed or initialed by the physician to indicate they were seen. Abnormal results should have an explicit notation about follow-up plans.
- A written report should be sent to the member's PCP. This applies to ALL referrals except referrals for prenatal care. If a copy of the progress notes was sent to the PCP, the specialist should document that this was done.
- Return visit – Encounter forms or notes should have a notation when indicated concerning follow-up care, call or visit or follow up with PCP. Specific time to return should be noted in weeks, months or PRN.

- Smoking habits, alcohol use and/or substance abuse should be noted for all Internal Medicine subspecialties, E.N.T., OB/GYN, and Orthopedic Surgeons. Patients should be encouraged to attend appropriate cessation programs as necessary.
- Unresolved problems from previous office visits should be addressed.
- Documentation should support appropriate patient education.