MEDICAL RECORD DOCUMENTATION (MRD)
ADMINISTRATIVE PRACTICE GUIDELINE

PROVIDER TYPE: Primary Care Physicians (PCPs) and specialist physicians except psychiatrists

SCOPE: Adult and pediatric medical records in an inpatient and/or outpatient setting

STANDARD: 84%

TARGET POPULATION: All members

OUTCOME/PROCESS INDICATOR(S):
- Medical records are maintained in a legible, current, detailed, organized, confidential and comprehensive manner which permits effective quality management review and assessment of appropriate health management and continuity of care.

GUIDELINE:
- The physician must develop and maintain a system for collection, processing, maintenance, storage, retrieval and distribution of medical records in a current, detailed and comprehensive manner that permits effective member care and quality review.
- Records must reflect all aspects of the member’s care including ancillary services.
- Records must show evidence of appropriate member consents or informed refusal of tests and/or therapies.
- Records shall be easily located and available at each member encounter.
- Records will be available within seven (7) days of receipt of request for medical records
- Records will be transferred to a new physician at the member’s request. The records will be transferred within thirty (30) days of the member’s signed release or written request so as to not interfere or cause delay in the provision of services to the member.
- Except as required by law, all member’s records will be treated in a strictly confidential manner and will be reasonably protected from loss, tampering, alterations, destruction and all unauthorized or inadvertent disclosure of information. The physician shall have in place appropriate administrative, technical and physical safeguards to protect the privacy of protected health information.
- All records shall be legible.
- The medical record must be capable of being read alone by anyone who has the need to understand the clinical information carried therein.
- Only standard abbreviations are to be used in the medical record. Should circumstances dictate the use of non-standard abbreviations, they must be identified with their first use in the medical record or a list of abbreviations used within the medical record must be maintained with the medical record.
• Personal/biographical data to include: full name, date of birth, gender, address, employer, home and/or work telephone numbers and marital status.

• Medical records will reflect all aspects of medical care including ancillary services.

• Within the member’s record, there shall be documentation of:
  – A current and complete history including past medical history, family history, social history and physical examination. For children and adolescents (18 years and younger), past medical history as it relates to pre-natal care, birth, operations, development and childhood illness shall also be recorded.
  – Smoking habits and history of alcohol use or substance abuse for members 12 years and older.
  – Problem list for medical/surgical conditions revised and kept current.
  – Any or all allergies and/or untoward reactions to drugs or medications shall be documented.
  – Current or recently used medications documented on a medication list which will include notation of the indication for the medication, the dosage and frequency of the medication.
  – An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
  – Any immunization record transfer from another office will be included in the medical record and must be signed by the current treating physician.

• All medically-related communication with members whether by telephone, e-mail or any other means must be recorded in the medical record.

• All member-generated information (letters, e-mails or information entered over the Web or by any other means) must be entered into the medical record.

• The member and ambulatory care records shall demonstrate conformity with standard professional medical practice and permit effective quality management review.

• For each visit the following information will be required to be entered into the member’s medical record:
  – Chief complaint or purpose of visit.
  – Results of physical examination, including vital signs, with particular attention to examination of the parts of the body or organ system related to the member’s chief complaint or purpose of the visit with enough elements to form a working diagnosis consistent with the findings.
  – Working diagnosis or medical impression consistent with the history obtained and the physical findings.
  – Treatment plan, studies ordered, therapies administered, disposition and recommendations that are consistent with diagnosis. Additionally, any instructions provided to the member shall be recorded.
  – Laboratory and other studies as ordered. Any results of diagnostic tests are to be reviewed and initialed by the practitioner prior to incorporation into the member’s medical record.
  – Requested consultations.
  – Age-appropriate preventive services shall be offered in accordance with practice guidelines.
  – Date for return visit or timing of planned follow-up encounter shall be noted.
  – Date and author identification of individual providing the care (hand-written or unique electronic identifier).
  – All pages of the medical record should contain the member’s name or ID number.
The medical record shall reflect continuity and coordination of care with regard to follow-up for:

- Unresolved problems from previous visits.
- Consultation, laboratory and imaging reports, which shall be initialed and dated by the physician who ordered them to signify review. Review and signature by professionals other than ordering physician do not meet this requirement. (If reports are presented electronically or by some other method, there must be representation of review of the results by the ordering physician as well as documentation of the date of review).
- Abnormal results from consultants, laboratory as well as diagnostic and imaging studies requiring physician intervention, will have explicit notations in the records for follow-up.

The medical record shall reflect continuity and coordination of care with regard to correspondence among physicians and providers.

Follow-up by the primary care physician and/or specialist, as appropriate, with regard to:

- Hospital or other health care institution discharge.
- Emergency room encounters.
- Ancillary provider encounters.
- Specialist referral results.

Documentation regarding “advanced directives” shall be clearly documented in the medical record of members age 65 and over or those with life-threatening illnesses. A life threatening illness is defined as an illness that almost always leads to death in a fairly short period of time if left untreated, but may be chronic, or even cured, if dealt with early in the disease process.

The medical record does not reveal any evidence that the member is placed at an inappropriate risk by a diagnostic or therapeutic procedure.

All medical records shall be retained for at least seven (7) years from the date of the last service, or longer (particularly in the case of minors), if required by law.

All notes about a member are recorded in a timely manner: i.e., as close as possible to the time of the encounter. Corrections can be made to the member’s record when information has been entered erroneously or to clarify previous entries, provided the corrections or additions are clearly identified as subsequent entries by a date, time, initials and/or signature of the person making the entry.

NOTE: MRD Practice Guideline strives to remain consistent with the intent of directives from National Committee of Quality Assurance (NCQA), Joint Commission and Centers for Medicare & Medicaid Services (CMS) documentation guidelines.

TOOL(S): Chart Forms may be found on the BCNEPA Provider Center at www.bcnepa.com

REFERENCES:
49 PA Code Chapter 16 section 16.95 and Chapter 25 section 25.213
Standards and Guidelines for the Accreditation of Health Plans, National Committee for Quality Assurance 2010 Edition
DHHS Standards for Privacy of Individually Identifiable Health Information; Final Rule 12/28/00
PMSLIC Medical Record & Documentation Self-Assessment for Physician Office Practices
APPLICATION OF PRACTICE GUIDELINE:

This practice guideline applies to the following companies:

First Priority Life Insurance Company®
HMO of Northeastern Pennsylvania (d/b/a First Priority Health®)

APPROVAL:

Approved: Medical Quality Assurance Committee 12/06/89, 09/13/90, 12/12/91,
            12/20/91
            Medical Quality Management Committee 07/28/94
Revised:  Medical Quality Management Committee 04/11/96, 12/18/97
Revised:  Credentialing/Recredentialing Committee 01/12/99
Approved: Medical Quality Assurance Committee 10/24/91
            Medical Quality Management Committee 01/21/93, 04/15/93
            Specialty Quality Management Committee 06/09/94
Revised:  Specialty Quality Management Committee 10/01/96, 12/11/97
Revised:  Credentialing/Recredentialing Committee 01/18/00
            Credentialing Committee 01/15/02
            Credentialing Committee (Format Changes) 09/17/02
            Credentialing Committee 03/18/03
            Credentialing Committee 03/16/04
            Credentialing Committee 03/21/06
            Credentialing Committee 01/16/07
            Credentialing Committee 07/17/07
            Credentialing Committee 01/15/08
            Credentialing Committee 11/17/09
            Credentialing Committee 11/15/11
            Credentialing Committee 11/19/13
            Credentialing Committee 02/18/14