MEDICAL RECORD DOCUMENTATION (MRD)
ADMINISTRATIVE PRACTICE GUIDELINE

PROVIDER TYPE: Chiropractor

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:

• Chiropractors 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 accurately reflect the evaluation and treatment of the member.

• Records shall be available at each member encounter.

  Records will be available within seven (7) days of receipt of request for medical records

• Records must show evidence of appropriate member consents or informed refusal of tests and/or therapies.

• Records will be transferred to a new chiropractor 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 chiropractor shall have in place appropriate administrative, technical and physical safeguards to protect the privacy of the 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, will be maintained in the medical record.

- Medical records will demonstrate conformity with standard chiropractic practice and reflect all aspects of care.

- Within the member’s chart, there shall be documentation of:
  - A current and complete history including past and present medical treatment, chiropractic care, attempts at self-care, family history and physical exam.
  - A problem list for medical/surgical conditions revised and kept current.
  - Any and all allergies and/or untoward reactions to drugs or medications shall be documented.
  - Current or recently used medications documented on a medication list which include notation of the indication for the medication, the dosage, and frequency of the medication.

- For each visit, the following information will be required to be entered into the member’s medical record to document sufficient information to substantiate the clinical necessity for the chiropractic care rendered, ordered or prescribed:
  - Chief complaint or purpose of visit.
  - Review of systems (as appropriate) and physical findings which are pertinent to the complaint.
  - Precise level and/or area of the spine, which is affected by the malalignment identified; i.e., vertebral subluxation(s).
  - Quantitative measurement of physical limitations and/or extent of injury.
  - Diagnosis or clinical impression.
  - Plan of care, disposition, recommendations and instructions to the member.
  - Date and author identification of individual providing the care (handwritten or unique electronic identifier).
  - All pages of the medical record should contain the member’s name or ID number.

- Appropriate health management and continuity of care will be clearly reflected in the medical record:
  - Follow-up documented on the encounter including date for return visit.
  - Problems from previous visits addressed.
  - Documentation of follow-up to primary care physician:
    - Discussion with member regarding continuity of care via PCP notification;
    - Documentation of member’s approval or decline of PCP notification; and
    - Documentation of follow-up to PCP within two (2) weeks with member approval.
  - Referral to another health care provider.

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

• All notes about the member will be recorded in a timely manner; i.e., as closely as possible to the time of the visit. Corrections can be made to the record when information has been entered erroneously or to clarify previous entries, provided the corrections or additions are clearly identified as subsequent entries by 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.

TOOLS: Chart Forms may be found on the BCNEPA Provider Center at www.bcnepa.com

REFERENCES:
49 Pennsylvania Code Chapter 5 section 5.51
DHHS Standards for Privacy of Individually Identifiable Health Information; Final Rule 12/28/00.
PMSLIC Medical Record & Documentation Self-Assessment for Physician Office Practices
Clinical Documentation Manual from the American Chiropractic Association (2005)

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®)

APPROVALS:

Approved: Medical Director 01/05/98
Credentialing/Recredentialing Committee 03/23/00
Credentialing Committee 03/19/02
Credentialing Committee (Format Changes) 09/17/02
Credentialing Committee 03/18/03
Credentialing Committee 03/30/04
Credentialing Committee 03/21/06
Credentialing Committee 07/17/07
Credentialing Committee 01/15/08
Credentialing Committee 11/17/09
Credentialing Committee 08/16/11
Credentialing Committee 05/21/13
Credentialing Committee 02/18/14