HOME CARE MEDICAL RECORD DOCUMENTATION
ADMINISTRATIVE PRACTICE GUIDELINE

PROVIDER TYPE: Home Care

SCOPE: Adult and Pediatric Medical Records in a Home Health Agency

TARGET POPULATION: All members

OUTCOME/PROCESS INDICATOR(S):

- Medical records are maintained in a legible, current, detailed, organized, and comprehensive manner, which permits effective quality management review, and assessment of appropriate health management and continuity of care.

GUIDELINE:

- Home care service providers 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 all aspects of a member’s care, including ancillary services.

Records are available to health care practitioners and their staff at each encounter.

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

The comprehensive assessment must incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS). The home health agency is responsible for the collection of data, encoding and transmittal according to mandates of all regulatory bodies.

- Except as required by law, all member 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 home care service provider shall have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information. The home care service provider must advise the member of the agency’s policies and procedures regarding disclosure of clinical records.
• 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 may include: full name, date of birth, gender, address, employer, home and/or work telephone numbers, and marital or legal status; and guardianship information if relevant

• The home care service provider records shall demonstrate conformity with standard professional medical/nursing practice, and permit effective quality management review.

• All aspects of a member’s care shall be documented in the member’s home care medical record including:

  - Initial assessment.
  - Initial plan of care.
  - Updated plan of care.
  - Intermittent physician orders.
  - Interdisciplinary notes.

• For each skilled nursing and/or ancillary service visit, a progress note should be present on the member’s home care medical record within twenty-four (24) business hours of the visit which supports the plan of care and includes accurate and specific descriptions of at least the following:

  - Current medical condition.
  - Current mental status.
  - Homebound status.
  - Physician-ordered care given to the member during the visit.
  - Follow-up on previously identified problems.
  - New onset of symptoms
  - Teaching and training activities done with the member, caregiver, and/or significant other/which includes, but is not limited to, education regarding disease process, as applicable (documented from start of care date).
  - Response, capability and accuracy of member, caregiver, and/or significant other to perform the required care as taught.
  - Outcome of interventions.
  - Date and time that services were provided.
  - Signature/title of person providing services.
  - Date and follow-up plan for return visit.
  - Discharge plan
• Appropriate health management and continuity of care shall be clearly reflected in the home care medical record and at least the following shall be documented:

  Evidence that changes in medical and/or mental condition were reported to the physician and appropriate interventions occurred.

  Evaluation of progress toward short and long-term goal attainment (redefining of goals, if applicable).

  A record of scheduled physician appointments.

  Evidence of interdisciplinary action between all professional disciplines involved in the member’s care.

  Appropriate follow-up on diagnostic studies.

  Records of communication with the member regarding care, treatment, and services (for example, telephone calls or email), if applicable.

  Member generated information (for example, information entered into the record over the Web or in pre-visit computer systems), if applicable.

  A discharge summary which includes:

    A description of the member’s medical and mental status.
    Evidence of achieved goals.
    Follow-up instructions given to the member.
    Disposition of the member.
    Evidence that the discharge summary was sent to the Primary Care Physician and/or the specialist within seven (7) days of last visit.

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

TOOL(S):

• N/A

REFERENCES:

Health Care Financing Administration (HCFA): Conditions of Participation (42 CFR 484).
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:

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