Medical Record Keeping Reference Tool

All network practitioners are required to maintain paper or electronic medical records in a complete and orderly fashion which promotes efficient and quality patient care as well as professional medical review. Network practitioners are subject to the Health Plan’s periodic quality review of medical records to determine compliance to the following medical record standards.

### Confidentiality of Records

Office policies and procedures exist for the following:
- Confidentiality of the patient medical record
- Initial and periodic training of office staff concerning medical record confidentiality
- Release of information
- Record retention
- Availability of medical record when housed in a different office location (as applicable)

### Record Organization

An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations and within seven (7) business days for all other requests.

Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of:
- Identifiable order to the chart assembly
- Papers are fastened in the chart
- Each patient has a separate medical record

Medical records are:
- Filed in a manner for easy retrieval
- Readily available to the treating practitioner where the member generally receives care
- Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations.

Medical records are:
- Stored in a manner that ensures protection of confidentiality
- Released only to entities as designated consistent with federal requirements
- Kept in a secure area accessible only to authorized personnel
- Retained for a period of seven (7) years after the date of the last medical record entry, or
- Retained for a period of seven (7) years beyond the date of majority if the member is a minor

### Procedural Elements

Medical records are legible*

All entries are signed and dated

Patient name/identification number is located on each page of the record.

Linguistic or cultural needs are documented as appropriate

Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer (if applicable), contact information, marital status and an indication whether the patient’s first language is something other than English.

Mechanism for monitoring and handling missed appointments is evident

An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives.

A problem list includes a list of all significant illnesses and active medical conditions.

QUEST Integration Revised: July 2, 2014
**Medical Record Keeping Reference Tool**

| A medication list includes prescribed and over the counter medications and is reviewed annually* |
| Documentation of the presence or absence of allergies or adverse reactions is clearly documented in a prominent location on the record* |
| Documentation of any hospitalizations or ER usage |

### History

An initial history and physical is present to include:
- Medical and surgical history*
- A family history that minimally includes pertinent medical history of parents and/or siblings
- A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance abuse use/history beginning at age 11
- Current and history of immunizations of children, adolescents and adults
- Prenatal care and birth history for children

### Screenings of/for:
- Recommended preventive health screenings/tests
- Depression
- High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit
- Medicare patients for functional status assessment and pain
- Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

### Problem Evaluation and Management

Documentation for each visit includes:
- Appropriate vital signs (Measurement of height, weight, and BMI annually)
- Chief complaint*
- Physical assessment*
- Diagnosis*
- Treatment plan*

| Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines |
| Documentation of all elements of age appropriate federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) |
| Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets |

**Treatment plans are consistent with evidence-based care and with findings/diagnosis***
- Timeframe for follow-up visit as appropriate
- Appropriate use of referrals/consults, studies, tests

X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review

**There is evidence of practitioner follow-up of abnormal results***

Unresolved issues from a previous visit are followed up on the subsequent visit*

There is evidence of coordination with behavioral health provider

Education, including lifestyle counseling is documented

Patient input and/or understanding of treatment plan and options is documented

Copies of admissions, hospital discharge summaries, home health care reports, and emergency room care, physical or other therapies, as ordered by the practitioner are documented.

* Critical element