

Medical Record Requirements

Documentation Requirements

The medical record shall include the quality, quantity, appropriateness and timelessness of services performed.

The following standards are required for effective documentation of a member's health care record:

- 1) Records are to be kept as separate records for each enrollee.
- 2) The enrollee's identifying information, including name, enrollee identification number, date of birth, sex (gender) and legal guardianship (if any).
- 3) Each record must be in English, legible and maintained in detail.
- 4) The content, format and sequence of information are uniform in the record.
- 5) Each record shall contain a summary of significant surgical procedures, past and current diagnoses or problems.
- 6) Current medications and materials, including over the counter products along with any changes, including the name and dosage (when available) are to be documented at every patient encounter and recorded in a prominent uniform location in the patient's record.
- 7) Allergies and untoward reactions to medications are to be documented at every patient encounter, recorded in a prominent uniform location in the patient's record, and updated whenever new allergies or sensitivities are identified.
- 8) Each record is to contain signed documentation of HIPAA notification, or documented reason why member did not sign.
- 9) All entries must be dated and include department, if departmentalized.
- 10) All entries must indicate the chief complaint or purpose of the visit.
- 11) All entries must contain the objective.

- 12) All entries must contain the diagnoses/medical findings of the provider, consistent with the claim.
- 13) Each record contains a current medical history and an initial physical exam.
- 14) Documentation of vital signs, on all PCP encounters and/or specialist providers in which vital signs are in conjunction with the nature of the visit.
- 15) Documentation of height and weight on all PCP encounters and/or specialist providers in which height and weight are in conjunction with the nature of the visit.
- 16) Each record has progress notes.
- 17) All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG).
- 18) Timely entry and sequencing of lab and radiology data in records (14 days from date of test).
- 19) Appropriate and timely follow-up of findings of test/reports with results verified/signed off by the provider (14 days from date of test unless urgent).
- 20) Member clinical information is available to health care providers as needed anytime the office is open to members.
- 21) Enrollees are to be contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings that have been identified.
- 22) All entries must indicate therapies administered and prescribed.
- 23) All entries must be dated and signed with the health care professional's title. Include the name and profession of the provider rendering services (e.g., MD, DO, ARNP, PA, OD).
- 24) All entries must include the disposition, recommendations, and instructions to the enrollee.
- 25) All entries must include whether there was follow-up and outcome of services.
- 26) All records must contain an immunization history.
- 27) All records must contain information relating to the enrollee's use of tobacco products, alcohol, and or substance abuse in enrollees 12 years old or greater.
- 28) All records must contain summaries of all emergency care and hospital discharge summaries with appropriate medical follow-up for PCP and specific specialty provider.

- 29) To ensure continuity of care, timely summaries or pertinent records are obtained from previous provider(s) or organization(s) and incorporated into the member's medical record (14 days from request unless urgent).
- 30) Appropriate and timely referral for services, with letter(s) of correspondence between PCP and specialty providers.
- 31) Information on services by any provider, including but not limited to, family planning, preventive services, STD treatment and health and wellness services (with summaries or record of services provided elsewhere).
- 32) All records must reflect the primary language spoken by the enrollee.
- 33) Identify enrollees in need of communication or translation assistance in the delivery of health care services.
- 34) All records include notations of diagnosis or therapeutic interventions of clinical research, if applicable; clinical research interventions should be clearly contrasted with other entries.
- 35) All records include discussion with the patient concerning the necessity, appropriateness and risk of proposed surgery and discussion of treatment alternatives, by specialist and/or PCP.
- 36) All enrollee records must contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) by the PCP office.
- 37) Documentation that PCP office inquired if member has executed an advance directive. Neither Health Care District, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive. Include advanced directives executed by the enrollee.
- 38) 24 hour call-in information such as medication renewals, appointment cancellation, ER visits, significant medical advice, and after hour's telephone or online advice is documented/initialed as appropriate.
- 39) Provider follow-up with enrollee after a "missed appointment" or "no show".
- 40) Abbreviations and dose designations are standardized within the individual provider organization.

- 41) The medical record is maintained in a physically safe and secure environment where confidentiality of its contents is maintained. The medical record is protected from loss, tampering, alteration, destruction and unauthorized or inadvertent destruction.
- 42) There is a person designated to supervise the collection, processing, maintenance, storage, timely retrieval and distribution of records, and maintenance of a predetermined, secured and organized record format.
- 43) The medical record meets the requirement for retention of records, retirement of inactive records, timely entry of data in records, release of information contained in records.
- 44) All infants, children up to age five (5) and pregnant breast-feeding and postpartum women will be referred to the Florida WIC program.
- 45) PCP and OB/GYN offices will document that all women age 13 to 64 are given HIV counseling and offered HIV testing.

Other Related Medical Record Guidelines

The provider site must have a system in place that provides for the collection, processing, maintenance, storage, retrieval and distribution of medical records.

Providers must have policies in place that address the following regarding medical records:

1. Retention of active medical records
2. Retirement of inactive records
3. Timely entry of data in medical records
4. Release of information contained in medical records

A person in the provider's office should be designated as being responsible for medical records.

The responsibilities include, but may not be limited to, ensuring the following:

- Confidentiality, security and physical safety of medical records (confidentiality of medical records will include the confidentiality of a minor's consultation examination and treatment for sexually transmitted diseases)
- Compliance with the Health Insurance Portability and Accountability Act (HIPPA)
- Member information is protected from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure
- Timely retrieval of individual records upon request
- Unique identification of each patient's medical record
- Supervision of the collection, processing, maintenance, storage, retrieval and distribution of medical records
- Maintenance of a predetermined, organized and secured medical record format

Medical Record Transfers

Upon receipt of a signed Release of Medical Records form by a member or a parent/guardian of a minor, the provider must transfer copies of medical records within one week.