Medical record standards

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Quality health care requires standard documentation requirements to ensure consistency for the care of our members. These standards are reviewed annually to ensure they align with our current policies. These standards ensure effective medical record documentation and provide clear and consistent guidelines to ensure that providers maintain records in a current, organized, and effective manner. The medical record criteria that are encouraged for our network of independently contracted providers are outlined below.

1. Every page in the medical record contains the patient name or ID number.

2. Allergies/No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.

3. All presenting symptom entries are legible, signed and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.

4. The important diagnoses are summarized or highlighted.

5. A problem list is maintained and updated for significant illnesses and medical conditions.

6. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.

7. History and physical exam documentation identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan documentation is consistent with findings.

8. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or non-compliance to care plan).

9. Documentation of Advance Directive/Living Will/Power of Attorney discussion (including copies of any executed documents) in a prominent part of the medical record for adult patients is encouraged.

10. Documentation of continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical review will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/report from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/ provider reports.

11. Age appropriate routine preventive services/risk screening is consistently noted, i.e. childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

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