Medical Record Standards

Bakersfield Family Medical Group | Coastal Communities Physician Network

Heritage Provider Network and its affiliates require medical records to be maintained in a manner that is current, detailed and organized for effective and confidential patient care and quality review.

STANDARD	PERFORMANCE MEASURES
MEDICAL RECORD	
1. Elements in the medical record are organized in a consistent manner.	• Medical record is clearly organized. • Records are organized in chronological order. • Medical record does not contain information for other patients. Exception: Family members in one record must be clearly separated.
2. Medical Records are maintained and stored in a manner which protects the safety of the records and the confidentiality of the information.	• All medical records are stored out of reach and view of unauthorized persons. • Staff receive periodic training in patient information and confidentiality. • All practitioners with electronic medical records will maintain or have access to compatible electronic hardware and software that will enable the generation of a legible copy of the record in order to comply with patient and governmental access needs, and prepare and maintain a current back-up copy of electronic medical record files. • Upon meeting minimum record retention periods as defined by regulations, medical records should be discarded as follows: • For paper records, by incineration, shredding, pulping, or other comparable process which renders the records permanently unreadable; • For electronic or magnetic media, such as computer disks or magnetic tapes, by completely sanitizing the media, and not just by erasure or deletion; • For other media, such as film, photos, or compact discs, by destroying the media with no possibility of recovery; and • By complying with the HIPAA security provisions at 45 CFR §164.310(d), as amended.
3. Patient's name or identification number is on each page of record.	• Patient name or an identification number is found on each page in the record.
4. Entries are legible.	• Handwritten entries are legible to a reader other than the author. • Content of records is presented in a standard format that allows a reader, other than the author, to review without the use of separate legend/key.

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5. Entries are dated.	• Entries and updates to a record are dated. • All encounters are documented such as: well patient checkups, illness, care management or follow-up appointments, pre-travel visits, etc. • Documentation of medical encounters must be in the record within 72 hours or three business days of occurrence.
6. Entries are initialed or signed by author.	• Entries are initialed or signed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials. Applies to practitioners and members of their office staff who contribute to the record. • When initials are used, there is a designation of signature and status maintained in the office.
7. Personal and biographical data are included in the record.	• Personal biographic data include address, employer, home and work telephone numbers and marital status. • Includes information necessary to identify patient and insurer and to submit claims. • Information may be maintained in a computerized database, as long as it is retrievable and can be printed as needed to transfer the record to another practitioner or for monitoring purposes. • Name of the PCP for the patient is indicated in the record (in a group practice, the designated PCP may be documented in the office records).

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8. History A. Initial history and physical examinations for new patients are recorded within 12 months of a patient first seeking care or within three visits, whichever occurs first. B. Past medical history is documented and includes serious accidents, operations and illnesses. C. Family history is documented. D. Birth history is documented for patients age 6 and under.	A. Initial history and physical examinations for new patients are recorded within 12 months of a patient first seeking care or within three visits, whichever occurs first. If applicable, there is written evidence that the practitioner advised the patient to return for a physical examination. The records of a complete history and physical, included in the medical chart, and done within the past 12 months by another physician, will satisfy this standard. In pediatric practices, well child visits satisfy this standard. A&B. History and physical documentation contains pertinent information such as age, height, vital signs, past medical and behavioral health history, preventive health maintenance and risk screening, physical examination, medical impression, and the ordering of appropriate diagnostic tests, procedures, and medications. Self-administered patient questionnaires are acceptable to obtain base line past medical history and personal information. There is written documentation to explain the lack of information contained in the medical record regarding the history and physical (e.g., poor historians, patient's inability or unwillingness to provide information). C. Patient record contains immediate family history or documentation that it is non-contributory. D. Pediatric records should include gestational and birth history documentation; should be age and diagnosis appropriate.
9. Allergies and adverse reactions are prominently listed or noted as "none" or "NKA".	• Medication allergies or history of adverse reactions to medications are displayed in a prominent and consistent location or noted as "none" or "NKA". (Examples of where allergies may be prominently displayed include on a cover sheet inside the chart, at the top of every visit page, or on a medication record in the chart.) • When applicable and known, there is documentation of the date the allergy was first discovered.
10. Information regarding personal habits such as sexual behavior, smoking and history of alcohol use and substance abuse, or lack thereof, is recorded.	• Primary care physician must have documentation in the record regarding smoking habits, sexual behavior and history of alcohol use and substance abuse for patients, 12 years of age and older, who have been seen three or more times.

STANDARD	PERFORMANCE MEASURES
11. An updated problem list is maintained.	• A problem list which summarizes important patient medical information, such as a patient's major diagnoses, past medical and/or surgical history, and recurrent complaints, is documented. • Continuity of care between multiple practitioners in the same practice is demonstrated by documentation and review of pertinent medical information.
12. Patient's chief complaint or purpose for visit is clearly documented.	• A patient's chief complaint or purpose for a visit as stated by the patient is recorded. The documentation supports that the patient's perceived needs/expectations were addressed. • Telephone encounters (phone contact) relevant to medical issues are documented in the medical record and reflect practitioner review.
13. Clinical assessment and/ or physical findings are recorded. Working diagnosis is consistent with findings.	• Clinical assessment and physical examination are documented and correspond to the patient's chief complaint, purpose for seeking care and/or ongoing care for chronic illnesses. • Working diagnoses or medical impressions that logically follow from the clinical assessment and physical examination are recorded.

STANDARD	PERFORMANCE MEASURES
14. Plans of action/treatment are consistent with diagnosis(es).	• Proposed treatment plans, therapies or other regimens are documented and logically follow previously documented diagnoses and medical impressions. • Rationale for treatment decisions appears medically appropriate and substantiated by documentation in the record. • Laboratory tests are performed at appropriate intervals.
15. There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.	• The medical record shows clear justification for diagnostic and therapeutic procedures.
16. Unresolved problems from previous visits are addressed in subsequent visits.	• Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes.
17. Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.	• Return to Office (RTO) in a specified amount of time is recorded at time of visit, or as follow-up to consultation, laboratory or other diagnostic reports. • Follow-up is documented for patients who require periodic visits for a chronic illness and for patients who require reassessment following an episodic illness. • Patient involvement in the coordination of care is demonstrated through patient education, follow up and return visits.
18. Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated as needed.	• Information regarding current medications is readily apparent from review of the record. • Changes to medication regimen are noted as they occur. When medications appear to remain unchanged, the record includes documentation of at least annual review by the practitioner. • When the patient is being seen by multiple practitioners, such as specialists or behavioral health practitioners, there is documentation of consideration of medication interaction.
EDUCATION	

STANDARD	PERFORMANCE MEASURES
19. Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated as	• Education may correspond directly to the reason for the visit, or to specific diagnosis-related issues, such as dietary instruction to reduce cholesterol. • Examples of patient noncompliance are documented.
SCREENING AND PREVENTIVE CARE PRACTICES	
20. Screening and preventive care practices are in accordance with Preventive Health Guidelines.	• Each patient record includes documentation that preventive services were ordered and performed, or that the practitioner discussed preventive services with the patient and the patient chose to defer or refuse them. Practitioners may document that a patient sought preventive services from another practitioner, e.g., OB/GYN.
21. An immunization record is completed for all patients.	• The patient record includes documentation of immunizations administered from birth to present for pediatric patients, and applicable immunizations for adult patients. • Provider shall document: ▪ Attempts to provide immunizations. ▪ Voluntary refusal of the immunization in the form of a signed statement by the patient or guardian of the patient. ▪ If the responsible party refuses to sign this statement, the refusal shall be noted in the Patient's Medical Record. • When prior records are unavailable, practitioners may document that a child's parent or guardian affirmed that immunizations were administered by another practitioner and the approximate age or date the immunizations were given.
CONSULTATION/SPECIALTY REFERRAL	
22. Requests for consultation are consistent with clinical Assessment/ physical findings.	• The clinical assessment supports the decision for a referral. • Referrals are provided in a timely manner according to the severity of the patient's condition.
ANCILLARY, DIAGNOSTIC AND THERAPEUTIC SERVICES	

STANDARD	PERFORMANCE MEASURES
23. Laboratory and diagnostic reports reflect practitioner review.	• Results of all lab and other diagnostics are documented in the medical record. • Records demonstrate that the practitioner reviews laboratory and diagnostic reports and makes treatment decisions based on report findings. Reports within the review period are initialed and dated by the practitioner, or another system of ensuring practitioner review is in place.
24. Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented.	• Patients are notified of abnormal laboratory and diagnostic results and advised of recommendations regarding follow-up or changes in treatment. The record documents patient notification of abnormal results. A practitioner may document that the patient is to call regarding results; however, the practitioner is responsible for ensuring that the patient is advised of any abnormal results.
CONTINUITY OF CARE	
25. There is evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.	• Consultation reports reflect practitioner review. • Primary Care Physician records include consultation reports/summaries (within 30-60 days) that correspond to specialist referrals, or documentation that physician attempted to obtain reports that were not received. Subsequent visit notes reflect results of the consultation as may be pertinent to ongoing patient care. • Specialist records include a consultation report/summary addressed to the referral source. When a patient receives services at or through another provider, such as a hospital, emergency care, home care agency, skilled nursing facility or behavioral health specialist, there is evidence of coordination of care through consultation reports, discharge summaries, status reports or home health reports. The discharge summary includes the reason for admission, the treatment provided and the instructions given to the patient on discharge.
BEHAVIORAL HEALTH	

STANDARD	PERFORMANCE MEASURES
26. Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities, or consultants. If the patient refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented.	Treatment record standards are established to facilitate communication, coordination and continuation of care between the primary care practitioner and the behavioral health provider. 1. Exchange of information demonstrating coordination to include: 2. For Psychiatrists: Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the patient from the onset of care through discharge 3. The behavioral health history which includes an assessment of any history of abuse the patient has experienced 4. Documentation of a DSM-IV-TR or successor diagnosis, including all five axes, consistent with the presenting problem(s), history, mental status examination, and other assessment data
	5. Treatment plan documentation needs to include the following elements: • Specific symptoms and problems related to the identified diagnosis of the treatment episode • Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such.