Professional Practice Medical Record Documentation Guidelines

INTRODUCTION

Consistent and complete documentation in the medical record is an essential component of quality patient care. All Participating Providers, defined as primary care and specialist practitioners, are required to keep medical records that contain patient demographics and current, detailed, medical information regarding services rendered to Members to facilitate communication and promote efficient and effective treatment. Medical records must be maintained in an organized medical record-keeping system and in compliance with Capital BlueCross’ documentation standards for Traditional, Comprehensive, PPO, POS, Keystone Health Plan® Central, SeniorBlue® PPO and SeniorBlue® HMO Members.

Complete medical records must be maintained for every Member in accordance with accepted professional practice standards, State and Federal requirements. In addition, they must meet the Pennsylvania Department of Health’s guidelines for managed care organizations. Medical records and information must be protected from public access and any information released must comply with HIPAA guidelines. Upon request, all participating practitioners’ medical records must be available for utilization and quality improvement review studies, retrospective review of claims, as well as regulatory agencies’ requests and member relations’ inquiries, as stated in the Provider agreement. Medical records must be available at the practice site for other Providers who provide care and services to the patient.

Guidelines have been developed for medical record review that are intended to assist Providers in maintaining complete medical records for all Members. Each provider must meet a minimum 70% compliance with medical record guidelines. If this level of compliance is not met, a corrective action plan will be required. The guidelines, included in Exhibit 3 of this Manual, were developed to comply with state and national regulatory requirements.

For POS, Keystone Health Plan® Central, SeniorBlue® HMO and SeniorBlue® PPO Members, medical records will be assessed at practices during quality reviews based on these standards. Across the network, there is a goal of 90% compliance for each measurement.

STRUCTURAL

1. Patient Identification

   All pages in the medical record must contain the patient’s name or identification number. Patient identification on one side of the page is acceptable. If the page is unused, identification is not necessary. Documentation that is on sticky notes, index cards, etc., (extraneous to the medical record) is not acceptable.
2. **Signature/Initials & Credentialing**

All entries in the medical record must contain legible author identification, date of service and physician credentials. The signature can be handwritten or it can be electronic with authentication. Some examples of acceptable authentication include but are not limited to: Electronically signed by, finalized by, or validated by. Initials may be used as long as the respective physician’s credential is included.

Physician Assistants and Residents in office training programs must have the co-signature of the Supervising Physician. Certified Registered Nurse Practitioners (CRNP) do not require co-signatures.

3. **Organized System for Maintaining Documents in the Record**

Documents must be filed in the record in an organized manner.

4. **Organized Filing System for Unique Patient Files**

Unique patient files must be stored in an organized manner that allows for easy retrieval.

5. **Medical History Information**

5. **Problem List Present**

The medical record must contain a problem list including, but not limited to:

- Past medical history
- Chronic or significant ongoing acute medical conditions
- Significant surgical conditions
- Significant behavioral health conditions

For children and adolescents (18 years and younger), prenatal care, birth, surgery and childhood illnesses should be documented on this list as appropriate.

6. **Problem List Current**

Problem lists must be up to date and include all diagnoses made by any clinician involved in the member’s care or confirmed in hospitalizations.

7. **Medication List Present**

The medical record must contain a medication list, which includes all current and previously ordered medications prescribed for chronic conditions with the name, dosage, frequency and quantity of the medication prescribed. The list must include medications ordered by any clinician involved in the member’s care. This list can be located within the progress notes if it is documented at every visit. The treatment plan in the progress notes
should also contain documentation of all new medications prescribed with the name, dosage, frequency and quantity prescribed.

8. **Medication List Current**

Medication Lists must be up to date and include all medications prescribed by any clinician involved in the member’s care or noted in hospital discharge summaries. 

9. **Allergies**

Any or no allergies or adverse reactions to drugs must be documented prominently and consistently displayed.

10. **Provider Coordination of Care**

The medical record must contain documented evidence of continuity and coordination of care for all ancillary services and diagnostic tests ordered by the Provider.

11. **Consultant Continuity of Care**

The medical record must contain documentation of all referred diagnostic and therapeutic services, including, but not limited to:

- Provider (primary care or specialist) notes
- Physical therapy notes
- Home health nursing notes
- Emergency room records
- Operative reports
- Hospital discharge summaries

12. **Advance Directive**

There must be documentation in a prominent part of the record as to whether or not the adult patient [age 18 and older] has executed an Advance Directive. This documentation is required by Centers for Medicare and Medicaid Services (CMS). CMS also requires that if the member has an advanced directive, it should be found in a Prominent/Consistent place in the medical record.

**MEDICAL CARE**

13. **History/Physical Exam**

A history/physical exam must be documented in the progress note and must be specific to the situation for each patient, each encounter, and each presenting complaint. This documentation must also reflect any variation from other similar visits. “Exam Normal” as the only documentation is not compliant.

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1 Variations in EMR software that do not show the previously ordered medications on the current list will be considered if discontinued medications are available to the practitioner elsewhere in the medical record.
14. **Working Diagnosis**

The diagnosis must be consistent with the findings. There must be a medical diagnosis (written by the Provider) for each presenting complaint or abnormal finding on the physical exam for each visit.

15. **Return Visit**

The return visit is a date for follow-up with the primary care office. Every visit is to have a follow-up noted. If follow-up for a specific diagnosis is not required, document “return prn” or “return as needed”.

16. **Appropriate Treatment—Presenting Complaints**

Clinical management, with documentation of diagnostic tests and services, must be appropriate for the condition/presenting complaints. Peer review will address quality issues regarding appropriateness of care. Examples of quality reviews may involve a question of:

- Failure to document diagnoses and complete treatment plans
- Failure to document medical necessity for treatment provided
- Diagnostic studies ordered which are inappropriate to the treatment of the condition
- Failure of timely use of consultants
- Failure to provide diagnosis resolution

17. **Appropriate Treatment—Preventive Health/Risk Screening*\**

Documentation must reflect recommendation of preventive care guidelines that are age appropriate, including:

- Physical exam of more than the presenting complaint
- Health history and appropriate screening
- Health education or anticipatory guidance

18. **Patient Input**

There must be documented evidence that the Member was advised and had input as to treatment options, risks, benefits and consequences of treatment or non-treatment.

- Documentation that “patient understands instructions” or the abbreviation “PUI” is acceptable at the end of every office visit
- When the patient refuses any recommended treatment, there must be documentation in the record that the patient was informed of the consequences of non-treatment and treatment options were discussed between the provider and the patient
- Informed consent is the use of a signed consent form when a patient agrees to undergo specific medical intervention. This must be part of the medical record
PRIVACY

19. Medical Records are protected from Public Access
   - Medical records must be stored in a secure manner that allows access by authorized personnel only

20. Staff Confidentiality Training
   - Practice office staff must receive periodic training in member information confidentiality

*May not be applicable to some specialty practices.