MEDICAL RECORD POLICY AND PROCEDURES

Security of Medical Records

1. The medical record will be secure and inaccessible to unauthorized persons in order to prevent loss, tampering, disclosure of information, alteration or destruction of the record.

2. Information must be accessible only to authorized staff within the physician's office, contracted health plans, DHS or to persons authorized through a legal instrument (i.e., subpoena).

3. As per the Provider Agreement/Contract, provisions must be made for the contracted health plan to have appropriate access to the member's medical records for purpose of quality review.

Release of Medical Records and Distribution

1. Patient information and records shall be protected for confidentiality according to the Confidentiality of Medical Information Act which prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's written consent or specific legal authority.

2. Patient information in a medical record may only be released under the following conditions:

    a. The attorney or representative of the patient may receive a copy of the medical record after presenting a signed authorization from the patient or his/her representative. The patient must present identification when requesting a copy of his/her medical record. Outside health care providers: Federal, State, County or City agencies; employers; and insurance companies may also receive a copy of the patient record, with the patient's authorization.
    b. Any release in response to a court order or to authorized persons will be reported to the patient in a timely manner.
    c. Member records may be disclosed, with or without patient authorization, to qualified personnel for the purpose of conducting scientific research, but these records must not identify, directly or indirectly, an individual patient in any report of the research or otherwise disclose participant identity in any manner to prevent divulging confidential information.
    d. In accordance with individual Provider Agreements/Contracts, health plan representatives are provided appropriate access to members' medical records for the purpose of quality review.

3. Only the Medical Record Department or assigned personnel responsible for the maintenance of medical records may provider written documents or copies of patient records.

4. Authorization forms permitting release of medical records must specify whom the information is requested by, the type of information requested and the dated signature of the patient or patient representative. The patient's name, medical record number, name and organization of the requester, date of the request and date the record was released must be documented and filed in the medical record.

5. Minors have the right to access confidential services without parental consent, therefore those medical records and/or information regarding medical treatment specific to those confidential services are not to be released to parent(s) without the minor's consent.

Storage and Maintenance

1. Medical records will be stored in one central medical record area and must be inaccessible to unauthorized persons. The medical record area need not be locked if staff is present.

2. Medical records are to be maintained in a manner that is current, detailed, organized; permits effective patient care and quality review and maintain confidentiality.

3. All medical records will be maintained for a minimum of ten (10) years following patient discharge, except minors. Records of minors must be maintained for at least (1) year after a minor has reached age 18, but in no event for less than ten (10) years.

4. Printed chart contents will securely fastened, attached or bound to prevent medical record loss.

5. The records must be filed alphabetically, numerically and/or color coded for easy retrieval.

6. Each patient must have his own medical record. No “family” charts are allowed.

7. Medical records will allow for prompt retrieval of the medical records and must be available to the provider at each encounter.

8. Medical records will be properly filed. They will not be piled on the floor, tumbling out of the racks/storage nor packed tightly in the racks so as to obstruct access.

9. Medical records are not to be accessible to patients, therefore must be collected after use a put in the assigned area.

10. Medical records with lab, x-ray or consultation reports or other information that has not yet been reviewed by the provider will be collected and stored in a predetermined area for the provider’s review.

Consent for Treatment

1. Consent for treatment must be given at the time of initial office visit by the member, parent or guardian by signing a consent to treat form for either an adult or child as appropriate.

2. The consent to treat form will be maintained in the patient’s medical record.

3. Minors have the right to access confidential services without parental consent. Therefore minors are authorized to sign their consent to treat form for any confidential services and/or information regarding medical treatment specific to those confidential services. Records and information are not to be released to parent(s) without the minor’s consent.

Medical Record Documentation

1. The medical record system permits prompt retrieval of information.

2. All pages in the medical record will be filed chronologically.

3. Each page in the medical record must have member identification that includes the member’s first and last name and/or a unique patient number (date of birth, medical record number, social security number).

4. The medical record will contain personal/biographical and demographic data that includes, but is not limited to, name, date of birth, age, sex, address, and telephone number and marital status. This information will be updated annually or as appropriate.

5. The medical record will include documentation regarding the member's emergency contact information. This will include the name and phone number of a relative or friend or a home, work, pager, cellular or message phone number. If the patient is a minor, the emergency contact must be a parent or guardian. Refusal or absence of an emergency contact must be noted in the medical record.

6. The member's primary language will be noted in the medical record.

7. The linguistic services needs for non- or limited English proficient members will be prominently noted in the medical record. Request for language and/or interpretation services will be documented. The member's refusal of these services will also be documented.

8. Allergies and adverse reactions are noted in the medical record in a prominent and consistent location. Absence of allergies or adverse reactions must also be noted using NKAD, NKA or none.

9. A clearly identifiable problem list will be maintained in the medical record that identifies all chronic and/or significant problems. The problem list will be currently maintained and will include a date the problem was identified as well as a date the problem was resolved (as applicable). Absence of chronic/significant problems will be noted on this list. Problems must be consistently listed in the progress notes if a problem list is not utilized.

10. A clearly identifiable medication list will be maintained in the medical record that identifies all long term or ongoing medications. This list will be currently maintained with the name of the medications. This list will be currently maintained with the name of the medication, strength, dosage, route, and start/stop dates. Discontinued medications will be noted in the progress notes and the stop date for the medication will be noted on the medication list. Medications must be consistently listed in the progress notes if a medication list is not utilized.

11. Documentation of whether the patient has executed an Advance Directive (a written instruction such as a living will or Durable Power of Attorney for health care relating to the provision of health care when the individual is incapacitated) or notation that information about Advanced Directives was given to the patient as required by Federal Law.

12. Entries are made in accordance with acceptable legal medical documentation standards. This will include:

    a. All entries are signed, dated and are legible.
    b. Signature includes the first initial, last name and title.
    c. Initials may be used only if signatures are specifically identified on a "signature page."
    d. Date includes the month, day and year.
    e. Only standard abbreviations are used in the medical record.
    f. Entries are in reasonable consecutive order by date.
    g. Notations made by hand must be made in black ink.
    h. Handwritten documentation does not include skipped lines or empty spaces where information may be added.
    i. Entries are not back dates or inserted into spaces above previous entries.
    j. Omissions are charted as new entries.
    k. Late entries are explained in the medical record and are signed and dated.

13. Entries into the medical record must be accurate, documented in a timely manner and legible to a person other than the author.

14. Errors made in the medical record will be corrected by drawing a single line through the error, with "error" written above or near the lined through entry. The corrected information is written above or near the lined through entry. The corrected

information is written as a separate entry and includes the date of the entry, signature (or initials) and title. There will be no unexplained cross outs, erased entries or use of correction fluid/tape. Both the original entry and corrected entry are clearly preserved.

15. Each focused/acute visit will include a documented history of the present illness. Physical exam relevant to the reason for the visit will be documented, which includes both normal and abnormal findings.

16. The diagnosis/impression is identified during each visit and will be documented defining the provider's conclusions.

17. Diagnostic information and a plan of treatment for each visit will be documented in the medical record.

18. Treatments, studies, procedures and tests, including results are to be documented and consistent with the diagnosis(es). Results of all diagnostic studies are filed in the medical records.

19. Specific follow-up instructions with a definite time from for a return visit or other follow-up plan for each encounter will be documented on the progress notes. The time period for return visit will be definitively stated in a number of days, weeks, months or PRN.

20. Unresolved problems from previous visits will be addressed in subsequent visits and documented on the progress notes.

21. Consultation reports, diagnostic test results, inpatient discharge reports, emergency and urgent care reports, and all abnormal and/or "STAT" reports will reflect the provider's review. The documents are to be filed in the chart within two weeks of service.

22. Provider will make explicit notations regarding abnormal test results/diagnostic reports. Documentation will include:
    a. All patient contacts
    b. Attempts made to contact patient
    c. Follow-up treatment
    d. Instructions given to patient
    e. Return office visits
    f. Referrals
    g. Other pertinent information.

23. There will be documentation of follow up for failed or missed appointments.
    Documentation will include:
    a. Attempt to contact patient/parent/guardian
    b. Results of follow-up actions.