healthfirst
Health Insurance for New Yorkers

Medical Record Documentation Standards

Healthfirst providers are required to maintain the medical records of members in a manner that is current, detailed, organized, and comprehensive and that permits effective patient care and quality review. The Clinical Quality department will conduct a review of members' Ambulatory Care medical records annually to determine compliance with Medical Record Documentation Standards.

Test scenarios should follow these guidelines

1. Patient's name and identification (ID) number on each page.
2. Personal biographical data, including the patient's date of birth, address, employer, home and work telephone numbers, and marital status.
3. A Problem List that is updated regularly to reflect current medications, significant illnesses, surgeries, and medical conditions.
4. Medication/food allergies and adverse reactions must be **prominently noted** in the record. If the patient has no known allergies or history of adverse reactions, this must be appropriately noted in the record.
5. Patient's medical history (for patients seen three or more times) must be easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), medical history relates to prenatal care, birth, operations, and childhood illnesses.
6. For patients 13 years and older, an appropriate notation concerning the use of cigarettes, alcohol, and illegal substances and a substance abuse history.
7. The history and physical exam identify appropriate subjective and objective information pertinent to the patient's presenting complaints and **must be updated annually**.
8. Laboratory and other studies are ordered as appropriate and results are included with the chart.
9. Working diagnoses are consistent with findings, and treatment plans are consistent with diagnoses.
10. Encounter forms or notes have a notation regarding follow-up care, calls, or visits. The specific time of the return is noted in weeks, months, or as needed.
11. Unresolved problems from previous office visits are addressed in subsequent visits.
12. If a consultation is requested, there is a note or letter from the consultant in the medical record.
13. Consultation, lab, and imaging reports filed in the chart must be initialed by a physician to signify review. Review and signature by a professional other than a physician, such as a nurse or physician assistant, does not meet this requirement. If the reports are presented electronically, or by some other method, there must also be indication of physician review. Consultations, abnormal lab and imaging study results must have an explanation in the record of follow-up plans.

(continued)

Test scenarios should follow these guidelines *(continued)*

14. There is an up-to-date immunization record for children (a note stating "immunizations up to date" is **not acceptable**). For adults, an appropriate history notation must be made in the medical record.
15. There is evidence that preventive screening and services are offered in accordance with Healthfirst's practice guidelines.
16. Evidence of reporting of public health cases to appropriate Public Health Agencies (e.g., STDs, TB, Lead Poisoning, Domestic Violence, etc.) is documented in the record.
17. A record of all emergency room (ER) visits and hospitalizations should be maintained in the medical record. If the provider receives a written notice regarding a member's ER visit/hospitalization from a Medical Management Case Manager, a copy of such notice should be made part of the member's medical record and a note documenting the member's present condition relative to the ER visit/hospitalization must be included on the Progress Note.
18. All entries are signed, stamped, or otherwise indicate the author's identity. All entries by a resident or PA are cosigned by an attending physician.
19. All entries are dated.
20. The record is legible to someone other than the writer. (A second reviewer will examine any record judged to be illegible by one reviewer.)
21. A Behavioral Health Screening Tool must be used to assess the mental health of PHSP Medicaid members, as appropriate.
22. The member's written consent to disclose personal health information (PHI) to Healthfirst.
23. Documentation of the risks of treatment versus no treatment for specific problems has been explained to the member.
24. Evidence of continuity and coordination of care between primary and specialty providers.
25. Documentation of prescriptions given, including drug name, dose, and date of initial and refill prescription.
26. Documentation of a discussion about Advance Directives for MHI Medicare members.