

# Medical Record Documentation Standards and Performance Measures

Compliance with the standards is monitored as part of our Quality Improvement Program. Practitioner refers to physicians or other health professionals who provide health care services.

Standard	Performance Measures
<b>MEDICAL RECORD</b>	
1. Elements in the medical records are organized in a consistent manner	<ul style="list-style-type: none"> <li>■ Medical records are clearly organized</li> <li>■ Medical records are organized in chronological order</li> <li>■ Medical records do not contain information for other patients Exception: Family members in one record must be clearly separated</li> </ul>
2. Medical records are maintained and stored in a manner which protects the safety of the records and the confidentiality of the information	<ul style="list-style-type: none"> <li>■ All medical records are stored out of reach and view of unauthorized persons</li> <li>■ Staff receive periodic training in member information and confidentiality</li> <li>■ All practitioners with electronic medical records will maintain or have access to compatible electronic hardware and software to generate a legible copy of the record to comply with patient and governmental access needs. In addition, practitioners should prepare and maintain a current back-up copy of electronic medical record files</li> <li>■ Upon meeting minimum record retention periods, as defined by regulations, medical records should be discarded as follows:               <ul style="list-style-type: none"> <li>□ For paper records, by incineration, shredding, pulping, or other comparable process which renders the records permanently unreadable</li> <li>□ For electronic or magnetic media, such as computer disks or magnetic tapes, by completely sanitizing the media, and not just by erasure or deletion</li> <li>□ For other media, such as film, photos, or compact discs, by destroying the media with no possibility of recovery</li> <li>□ By complying with the Health Insurance Portability and Accountability Act (HIPAA) security provisions at 45 CFR §164310(d), as amended</li> </ul> </li> </ul>
3. Patient's name or identification number is on each page of record	<ul style="list-style-type: none"> <li>■ Patient name or an identification number is found on each page in the record</li> </ul>
4. Entries are legible	<ul style="list-style-type: none"> <li>■ Handwritten entries are legible to a reader other than the author</li> <li>■ 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</li> </ul>
5. Entries are dated	<ul style="list-style-type: none"> <li>■ Entries and updates to a record are dated</li> <li>■ Documentation of medical encounters must be in the record within 72 hours or three business days of occurrence</li> </ul>
6. Entries are initialed or signed by author	<ul style="list-style-type: none"> <li>■ Entries are initialed or signed by the author with a handwritten signature, unique electronic identifier or initials. This applies to practitioners and members of their office staff who contribute to the record</li> <li>■ When initials are used, there is a designation of signature and status maintained in the office</li> </ul>

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<b>BASELINE DATA</b>	
<p><b>7. Personal and biographical data are included in the record</b></p>	<ul style="list-style-type: none"> <li>■ Personal biographical data include address, employer, home and work telephone numbers and marital status</li> <li>■ Includes information necessary to identify patient and insurer to submit claims</li> <li>■ 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</li> <li>■ Name of the practitioner for the patient is indicated in the record (in a group practice, the designated practitioner may be documented in the office records)</li> </ul>
<p><b>8. 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>  <b>B—Past medical history is documented and includes serious accidents, operations and illnesses</b>  <b>C—Family history is documented</b>  <b>D—Birth history is documented for patients age 6 and under</b></p>	<ul style="list-style-type: none"> <li>■ <b>A</b>—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</li> <li>■ <b>A &amp; B</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 baseline 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)</li> <li>■ <b>C</b>—Patient record contains immediate family history or documentation that it is non-contributory</li> <li>■ <b>D</b>—Pediatric records should include gestational and birth history documentation; should be age and diagnosis appropriate</li> </ul>
<p><b>9. Allergies and adverse reactions are prominently listed or noted as none or no known allergies (NKA)</b></p>	<ul style="list-style-type: none"> <li>■ 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.)</li> <li>■ When applicable and known, there is documentation of the date the allergy was first discovered</li> </ul>
<p><b>10. Information regarding personal habits such as sexual behavior, smoking and history of alcohol use and substance use disorder, or lack thereof, is recorded</b></p>	<ul style="list-style-type: none"> <li>■ Practitioner must have documentation in the record regarding smoking habits, sexual behavior and history of alcohol use and substance use disorder for patients, 12 years of age and older, who have been seen three or more times</li> </ul>
<p><b>11. An updated problem list is maintained</b></p>	<ul style="list-style-type: none"> <li>■ 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</li> <li>■ Continuity of care between multiple practitioners in the same practice is demonstrated by documentation and review of pertinent medical information</li> </ul>

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<b>VISIT DATA</b>	
<b>12. Patient's chief complaint or purpose for visit is clearly documented</b>	<ul style="list-style-type: none"> <li>■ 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</li> <li>■ Telephone encounters (phone contact) relevant to medical issues are documented in the medical record and reflect practitioner review</li> </ul>
<b>13. Clinical assessment and/or physical findings are recorded. Working diagnosis is consistent with findings</b>	<ul style="list-style-type: none"> <li>■ 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</li> <li>■ Working diagnoses or medical impressions that logically follow from the clinical assessment and physical examination are recorded</li> </ul>
<b>14. Plans of action/ treatment are consistent with diagnosis(es)</b>	<ul style="list-style-type: none"> <li>■ Proposed treatment plans, therapies or other regimens are documented and logically follow previously documented diagnoses and medical impressions</li> <li>■ Rationale for treatment decisions appear medically appropriate and substantiated by documentation in the record</li> <li>■ Laboratory tests are performed at appropriate intervals</li> </ul>
<b>15. There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure</b>	<ul style="list-style-type: none"> <li>■ The medical record shows clear justification for diagnostic and therapeutic procedures</li> </ul>
<b>16. Unresolved problems from previous visits are addressed in subsequent visits</b>	<ul style="list-style-type: none"> <li>■ Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits are documented in subsequent visit notes</li> </ul>
<b>17. Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate</b>	<ul style="list-style-type: none"> <li>■ 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</li> <li>■ Follow-up is documented for patients who require periodic visits for a chronic illness and for patients who require reassessment following an episodic illness</li> <li>■ Patient involvement in the coordination of care is demonstrated through patient education, follow up and return visits</li> </ul>
<b>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</b>	<ul style="list-style-type: none"> <li>■ Information regarding current medications are readily apparent from review of the record</li> <li>■ 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</li> <li>■ When the patient is being seen by multiple practitioners, such as specialists or behavioral health practitioners, there is documentation of consideration of medication interaction</li> </ul>

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<b>EDUCATION</b>	
<p>19. Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated as appropriate</p>	<ul style="list-style-type: none"> <li>■ Education may correspond directly to the reason for the visit, or to specific diagnosis-related issues, such as dietary instruction to reduce cholesterol</li> <li>■ Examples of patient noncompliance are documented</li> </ul>
<b>SCREENING AND PREVENTIVE CARE PRACTICES</b>	
<p>20. Screening and preventive care practices are in accordance with the CareFirst BlueCross BlueShield Preventive Health Guidelines</p>	<ul style="list-style-type: none"> <li>■ 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</li> </ul>
<p>21. An immunization record is completed for all members</p>	<ul style="list-style-type: none"> <li>■ The patient record includes documentation of immunizations administered from birth to present for pediatric members, and applicable immunizations for adult members. 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</li> </ul>
<p>22. Requests for consultation are consistent with clinical assessment/physical findings</p>	<ul style="list-style-type: none"> <li>■ The clinical assessment supports the decision for a referral</li> <li>■ Referrals are provided in a timely manner according to the severity of the patient's condition</li> </ul>
<b>ANCILLARY, DIAGNOSTIC AND THERAPEUTIC SERVICES</b>	
<p>23. Laboratory and diagnostic reports reflect practitioner review</p>	<ul style="list-style-type: none"> <li>■ Results of all lab and other diagnostics are documented in the medical record</li> <li>■ 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</li> </ul>
<p>24. Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented</p>	<ul style="list-style-type: none"> <li>■ 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 the patient is advised of any abnormal results</li> </ul>
<b>CONTINUITY OF CARE</b>	
<p>25. There is evidence of continuity and coordination of care between primary and specialty care practitioners or other providers</p>	<ul style="list-style-type: none"> <li>■ Consultation reports reflect practitioner review</li> <li>■ Practitioner records include consultation reports/summaries (within 60-90 days) that correspond to specialist referrals, or documentation that practitioner attempted to obtain reports that were not received. Subsequent visit notes reflect results of the consultation that may be pertinent to ongoing patient care</li> <li>■ Specialist records include a consultation report/summary addressed to the referral source</li> <li>■ 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</li> </ul>

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Sources	
COMAR	Code of Maryland Related Regulations
MCHIP	Commonwealth of Virginia Regulation for the Certification of Managed Care Health Insurance Plan Licenses
NCQA	National Committee for Quality Assurance
VAC	Virginia Administrative Code

Practitioner Medical Record Standards and Performance Measures were reviewed in February 2018 and approved by the Corporate Quality Improvement Council on February 27, 2018.

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