Medical Record Standards

Goal

Medical record standards are established to help facilitate communication, coordination and continuity of care, and to promote good professional medical practice and appropriate healthcare management. A passing score of 85% is required. (The medical record standards in this document are a compilation of the standards required by the Centers for Medicare and Medicaid Services and the New Mexico Human Services Department).

Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) have established medical record standards to facilitate communication, to facilitate continuity and coordination of care, and to promote efficient and effective treatment. Presbyterian provides these standards to practices to address the following:

- Confidentiality of medical records.
- Medical record documentation standards.
- Organized medical recordkeeping system.
- Standards for the availability of medical records.
- Performance goals to assess the quality of medical record documentation.

In addition, Presbyterian has developed procedures to improve medical record documentation. The following standards have been defined for each category of the medical record documentation, and for Presbyterian members.

Patient Identification

- Patient name or identification number (ID number) on all pages.
- Personal/biographical information (i.e., date of birth, patient address, employer, home, and work phone number(s)).
- Patient ethnicity documented on an Intake Form or with biographical information.

Quality of Medical Records

All medical record entries are to be documented as follows:

- Signed or co-signed, dated, and legible.
- History of current medical conditions noted and dated.
- Past medical history noted, easily identifiable, and to include serious accidents, operations, and illnesses for members having at least three (3) visits.
- Health maintenance is noted.
- Problems list is updated as necessary.
- Medication list (including both current and PRN medication) is updated as necessary; what is working? What is not working? And what medications were completed, renewed, or are new?
- Tobacco, alcohol, substance use, and sexual activity documented.
- Physical exams documented.
- Clinical findings and evaluation for each visit documented.

Advance Directives

All adult member charts should include documentation of Advance Directive discussion. An adult is any member age 18 or older. Documentation should include whether or not the patient executed an Advance Directive with a copy included in the medical record.

Adverse Reactions
Medication allergies and adverse reactions are prominently noted and dated in the record. If no known allergies, NKA (no known allergies) or NKDA (no known drug allergies) is noted.

Continuity and Coordination of Care

Labs/tests
- The PCP reviews results of all ancillary services and diagnostic tests or studies ordered by other practitioners. They may be initialed or a note indicating the lab work was reviewed may be present in the progress/office note.
- Documentation that the patient has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal lab or test results.

Consults
- Consultant's reports or documentation of discussions with consulting physicians should be in the medical record.
- Upon review of the consultant's reports and/or the specialty care provider's summary, the provider should initial or include a note indicating that the reports and/or summaries were reviewed. This documentation should be present in the progress/office note and fastened or secured in the chart.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as PRN (as-needed).
- There is a notation of any instructions/education given to patients regarding follow-up visits, care, treatment, or medication schedules, and diagnostic and therapeutic services where members are referred for services.
  - Home health nursing reports
  - Specialty physician reports
  - Hospital discharge reports
  - Outpatient/ambulatory surgery reports

Immunization Record
Childhood, adolescent, and adult immunizations per the State and National Preventive Health Guidelines.

Lead Screening
Lead screening per state requirements and at the physician's discretion based on National and State requirements or individual risks.

Preventive Healthcare Services
Preventive healthcare services should be noted in the medical records for all members, including EPSDT. The information should include the following:
- Evidence of required age-specific preventive screenings based on approved national practice guidelines and New Mexico Human Services Department Requirements.
- Obesity screening with each physical exam and EPSDT visit, which shall include assessment and documentation of age, height, and gender appropriate weight, height/length measurements, and BMI percentile designation.