MEDICA®

Policy Title:	**Medical Records: Provider Responsibilities**
Department:	Health Services
Business Unit:	Quality Improvement
Approved By:	Cara Broich, Director, Quality Improvement and Credentialing
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SCOPE
This policy applies to all health care providers contracted to serve Medica members.

PURPOSE
Medica has developed and adopted the following guidelines for Medica health care providers to follow for documentation in members' medical records. Guidelines are based on the standards and regulations of:

- Minnesota Department of Health (MDH)
- Minnesota Department of Human Services (MDHS)
- Centers for Medicare and Medicaid Services (CMS)
- U. S. Department of Health and Human Services (HHS)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- National Committee for Quality Assurance (NCQA)
- American Health Information Management Association (AHIMA)
- Minnesota Health Information Management Association (MHIMA)
- The practicing medical community

Medica adopted these guidelines to improve continuity and quality of patient care by assuring timely, legible, accurate and comprehensive documentation of patient-provider interactions. Well-documented medical records, whether electronic or on paper, facilitate communication, coordination and continuity of care, as well as promoting efficiency and effective treatment.

POLICY

A. Overview

Medical records belonging to Medica members, electronic or paper, communicate the member's past medical treatment, past and current health status and plans for future health care. Prior pertinent medical record information is available to the attending practitioner when a medical judgment is made. Medical records are organized in a consistent manner to permit efficient information retrieval. Medical records are used in a manner that maintains the member's confidentiality. Records are stored in a secure fashion.

B. Record Management

The medical record is maintained to ensure that:

1. Confidentiality of the medical record is maintained according to existing law through policies and procedures for protecting medical record confidentiality and release of information. Medical records are stored in a secure area that is inaccessible to unauthorized individuals, as defined by the clinic. Medical records and patient reports are processed (completed, transported, filed, stored, etc.) in a manner identifiable to clinic staff only.

2. Records are retrievable. A single, permanent medical record is maintained for each patient. The clinic has a system in place by which the patient's complete medical record is available for all routinely scheduled office visits. Contents of paper medical record are affixed and organized in a consistent manner.

3. Continuity of care is maintained through policies and procedures to include:
   a. Documentation of all treatment-related telephone contacts.
   b. Documentation of after-hours patient/physician contact.
   c. A process to review failed appointments, determine necessity for patient contact and follow-up as necessary.
   d. A process to review and, as needed, arrange for follow-up to laboratory studies, x-ray procedures, consultations, ER visits, hospitalizations or other care not directly provided by and/or documented in the chart by clinic staff.
   e. Documentation of communication between specialist and primary care provider
   f. Documentation of communication between ancillary services (PT,OT, home care, etc.), prescribing provider and/or primary care provider

C. Record Content and Format

1. General Documentation
   a. The medical record contains patient demographic information:
      - Patient name and/or identification number on every page
      - Age or date of birth
      - Address
      - Marital status
      - Occupation history
      - Home, mobile and work phone numbers
      - Name and telephone number of emergency contact

   b. All entries in the medical record are dated and identify the author, including the author's credentials. Author identification may be a handwritten signature, unique electronic identifier or initials. See Appendix for examples of acceptable and unacceptable signatures and credentials.
      i. If initials are used, the provider maintains a list of corresponding personnel names and titles.
      ii. The provider's policies and procedures stipulate that physicians use their own IDs and passwords to enter the EMR to sign medical records.

   c. Entries are legible by someone other than the author.

d. All pages in the medical record contain patient identification.

2. Problem Lists and Medication/Immunization Records
   a. An up-to-date problem list cites both chronic and acute conditions that affect patient management. The problem list includes dates of onset and resolution.

   b. The presence/absence of allergies/adverse reactions is documented in a consistent, prominent location. If the patient has no known allergies or adverse reactions, this is noted.

   c. Medication record includes name of medication, dosage, amount dispensed and dispensing instructions and is updated at every visit. The medication list includes over-the-counter medications.

   d. Immunizations are documented on a separate immunization record.

3. Medical, Family and Social History
   a. Documentation of family and social histories is present in the record and updated at least every five years.

   b. Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years and younger), past history relates to prenatal care, birth, operations and childhood illnesses.

   c. Smoking status (over 11 years of age), or exposure to second hand smoke is prominently displayed in the record. If the patient is a smoker, or exposed to second hand smoke, advice regarding smoking cessation is documented at every visit.

   d. Alcohol and substance use and abuse are documented.

   e. For all adult patients, there is a notation in the medical record that the patient has or has not executed an advance directive.

4. Hospital and Other External Records/Correspondence
   a. Patient hospitalization records are placed in the medical records within three weeks of discharge. Patient hospitalization records include, as appropriate:
      - History and physical
      - Consultation notes
      - Operative notes
      - Discharge summary
      - Other appropriate clinical information

   b. Consultation, lab, imaging and special studies reports are filed in the medical record and initialed by the provider to indicate review. Consultation and abnormal studies contain notation in the record for follow-up plan, as needed.

c. Specialty consultation or surgical center visit reports are placed in the medical record within three weeks of the visit.

d. Patient encounter documentation includes:
   - History and physical examination containing subjective and objective findings pertinent to the pertinent complaint
   - Unresolved problems from previous visits addressed in subsequent visits
   - A diagnosis consistent with findings
   - A treatment plan consistent with diagnosis
   - Lab and other studies ordered as appropriate
   - Patient education and counseling
   - Coordination of care, as appropriate, with other agencies
   - Notation regarding return visit or other needed follow-up care for each encounter (time of return is noted in days, weeks, months, years or as needed).

e. All appropriate preventive screening and services are documented. Refer to http://www.medica.com, Provider Resources, Medical Policies, ICSI Guidelines, for comprehensive guidelines for periodic health assessment and preventive screening.

D. Documentation for Risk Adjustment

Medica expects participating providers to follow the ICD-10-CM Official Guidelines for Coding and Reporting. CMS and HHS use ICD codes to perform risk adjustment, calculating payment rates based on member demographics and presence and severity of chronic conditions. The medical record must support the ICD coding for the associated claim(s) by, at minimum:

1. Documenting, to the highest level of specificity, all health conditions that coexist at the time of the encounter;
2. Documenting impact to patient care treatment or management (e.g. assessment, evaluation, treatment, monitoring and/or referral); and
3. Documenting all current health conditions not less than annually. Ongoing conditions do not "carry over" from past years and are assumed to have resolved if not reported on an annual basis.

E. Monitoring and Auditing

To comply with regulatory and accreditation requirements, Medica monitors participating providers' medical record documentation by methods that include, but are not limited to:

1. Clinical and Service Quality Review: A continuous quality improvement program that measures and evaluates medical record documentation and access to care. For more information, refer to http://www.medica.com, Provider Resources, Clinical & Quality Programs, Medical Record Review.

2. Claims validation: Medical record documentation is compared to submitted claims for consistency and accuracy.

3. Focused review: Medica staff may review medical records on a case-by-case basis if specific issues are identified through quality of care case review, claim review, or other referral sources.

4. HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS) is a standardized measurement set used to measure performance on important dimensions of care and service.

5. Risk adjustment review: Medica staff or designee may review medical records to meet risk adjustment requirements, including the risk adjustment data validation (RADv) audits required under the Affordable Care Act.

All participating providers are expected to comply with requests for medical records made by Medica. Providers must allow access to the complete electronic or hard copy medical record, including scanned documentation, for the time period specified by the requestor.

The performance thresholds for each standard vary based on previous scores. Thresholds are listed on the Corrective Action Plan request each year. If a document scores below the threshold on any standard surveyed, the provider is required to implement a corrective action plan for the unmet standard(s).

A. Medical Record Retention/Destruction

1. Medical records are retained, secured and destroyed according to the terms of the Provider Participation Agreement, consistent with all applicable state and federal regulations.

CROSS REFERENCES

- Clinical and Service Quality Review Program
- http://www.medica.com, Provider Resources
- Provider Administrative Manual, Chapters 13 and 14
- CMS Evaluation and Management Services Guide, December 2010
- CMS Documentation Guidelines for Evaluation and Management Services, 1997
- CMS Documentation and Guidelines for Evaluation and Management Services, 1995
- Medicare Program Integrity Manual
- MN Rule, 4685.1110, sub 13
- MHIMA Legal Manual
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2017

APPENDIX: Examples of Acceptable Signatures and Credentials

Types of **acceptable** provider signatures and credentials include:

Signature/Credential Type	**Acceptable**
Hand-written signature or initials, including credentials	Mary C. Smith, MD; or MCS, MD
Electronic signature, including credentials	Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by")

	Must be password protected and used exclusively by the individual physician

Types of **unacceptable** provider signatures and credentials include:

Signature/Credential Type	**Unacceptable UNLESS…**
Typed name	Authenticated by the provider
Non-physician on non-physician extender (e.g., medical student)	Co-signed by acceptable physician
Provider of services' signature without credentials	Name is linked to provider credentials or name on physician stationery

The Medicare Program Integrity Manual provides detailed examples of acceptable and unacceptable signatures and credentials: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html