

MVP Health Care Medical Record Standards and Guidelines

Well-documented electronic or paper medical records improve communication, and promote coordination and continuity of care. In addition, detailed medical records encourage efficient and effective treatment. For these reasons, MVP established standards for record keeping in medical offices that follow the recommendations of NCQA (National Committee for Quality Assurance). The standards are as follows:

- A. Providers must maintain complete and accurate medical records in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review.
- B. Providers must have an organized medical record keeping system.
 1. Medical records must be stored in a secure location not accessible to patients.
 2. There is a unique medical record for each member, identified by a medical record identifier on each page.
 3. Records are organized with a filing system to ensure easy retrievability.
- C. Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the practitioner, and all diagnostic and therapeutic services for which the practitioner referred the member. (e.g. home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports).
- D. Confidentiality – To protect the confidentiality of medical records and guard against unauthorized disclosure of patient information, physician practices will have written confidentiality policies and procedures that address confidentiality.
- E. Retention of Medical Records – Providers shall retain medical records according to applicable federal and state laws and regulations.
 - For providers participating in all New York Commercial and NY State Government Program products: medical record retention is required for a period of six (6) years after the date of service rendered to the enrollee and, for a minor, three years after majority of six years after the date of service.
 - In Vermont, providers are required to retain records for six (6) years after the date of service and, in the case of minors, until six (6) years after the age of majority.
 - For providers participating in Medicare products, medical record retention is required for a period of ten(10) years after the date of service rendered to the enrollee.
- F. Nondiscrimination in Health Care Delivery-MVP, as per CMS and NCQA, expect that providers have a documented nondiscrimination policy and procedure on file “to ensure that members are not discriminated against in the delivery of health care services based on, race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability(including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.”

Specific standards are as follows:

1. The medical record should be organized in such a way that data abstraction can be performed efficiently. Each page in the record should contain the patient’s name or ID number.
2. The record should be legible (for example, it can be read by someone other than the writer).
3. Each entry or office note must be dated.
4. All entries in the medical record should contain the author’s identification. For all entries dated after July 1, 1999, stamped signatures are not considered appropriate author identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
5. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient’s presenting complaints.

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6. Significant illnesses and medical conditions should be indicated on the problem list. A problem list should be completed for each patient, regardless of health status. A flow sheet for health maintenance screening is considered part of the problem list. It is acceptable if the practitioner outlines a problem list at each visit in the progress notes or if the practice site keeps a current ongoing problem list on a computerized system.
7. Past medical history (for patients seen three or more times) should be easily identified and should include serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
8. Medication list
9. Medication allergies and adverse reactions should be prominently noted in the record or on the front cover of the medical record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record, e.g. NKA.
10. For patients 14 years and older, there should be appropriate notation concerning the use of cigarettes, alcohol and other substances. For patients who have been seen three or more times, there should be a record of asking about any substance abuse history.
11. For all patients 18 and younger, there should be a completed immunization record. For patients over 18, there should be a note in the history of immunizations. Because most adults may not have an immunization record, appropriate notation should be made of Flu vaccine, Pneumococcal vaccine (if appropriate), and Tetanus/Diphtheria (Td) vaccine every 10 years.
12. Unresolved problems from previous office visits should be addressed and documented in subsequent visits.
13. Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
14. No shows or missed appointments must be documented with follow-up efforts to reschedule appointment.
15. Consultation, lab, and imaging reports filed in the chart should be initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or by some other method, there should also be representation of review by the ordering practitioner. Consultation, abnormal lab, and imaging study results should have an explicit notation in the record of follow-up plans.
16. If a consultation/referral is requested, there should be a note from the consultant in the record.
17. Lab and other studies ordered should reflect consideration of the reported signs/symptoms and recorded diagnoses.
18. Documentation of clinical findings and evaluation for each visit. Working diagnoses should be consistent with findings.
19. When indicated by diagnosis, plans of action should include the consultation of specialists. Treatment plans should reflect consideration of recorded diagnoses and reported signs/symptoms.
20. There should be no evidence that the patient was placed at inappropriate risk by a diagnostic or therapeutic procedure.
21. *For members over the age of 18, documentation of whether or not the patient has executed an advance directive. Documentation of any advance directive should be maintained in a prominent part of the member's medical record and should be kept up-to-date. Advance Directives can be found in the QI manual.
22. Preventive care/Risk Assessment-there is evidence that preventive screening and services are offered in accordance with MVP's practice guidelines.

* Required for Medicare and Medicaid members

MVP Health Care Medical Record Standards and Guidelines (continued)

To assess compliance with the standards, MVP conducts an annual ambulatory medical record review at the practice sites with 250 or more members on the following six core elements and Advance Directives on Medicare members:

- History and Physicals
- Allergies and adverse reactions
- Problem List
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening
- Advance Directives

A practitioner's medical records are considered to meet MVP's standards when the score for each of the six elements is 80% or greater. Practitioners who scored 100% on each element in the previous year will not be reviewed for the six core elements in the following year.

Actions for improving medical records:

- Practitioners that score below 80% on any one of the six elements will:
 1. receive a letter with recommendations for improvement with a copy sent to the IPA/PO Medical Director.
 2. receive notification that a re-review will be performed in six months on the elements that did not meet standards.
- Practitioner's who continue to score below 80% upon re-review will be contacted for a written corrective plan of action within 30 days. A copy of the request will be sent to the IPA/PO Medical Director. Upon receipt, a copy of the corrective action plan will also be forwarded to the IPA/PO Medical Director.
- Offices that do not submit an action plan will be presented to the IPA/PO or MVP Peer Review Committee for determination.
- Failure to cooperate with MVP QI activities or to correct deficiencies noted during the medical record review process will also result in notification of the IPA/PO Medical Director.
- Results of the ambulatory medical record review program will be reported to the Quality Improvement Committee.