

Medical Record Standards and Guidelines

Standard	Performance Measures
• MEDICAL RECORD	
1. Elements in the medical record are organized in a consistent manner, and the records are kept secure.	<ul style="list-style-type: none"> • Medical record is clearly organized. • Records are organized in chronological order. • Medical record does not contain information for other patients. • Medical records are maintained and stored in a manner that protects the safety of the records and the confidentiality of the information.
2. Patient's name or identification number is on each page of record.	<ul style="list-style-type: none"> • Patient name or an identification number is found on each page in the record.
3. Entries are legible.	<ul style="list-style-type: none"> • Handwritten entries are legible to a reader other than the author. • 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.
4. All entries are dated.	<ul style="list-style-type: none"> • All entries and/or updates to the record are dated. • Documentation of medical encounters must be in the record within 72 hours or three business days of the occurrence.
5. All entries are initialed or signed by the author.	<ul style="list-style-type: none"> • All entries are initialed or signed by the author. Applies to practitioners and members of their office staff who contribute to the record. • When initials are used, there is a designation of signature and status maintained in the office.
• BASE LINE DATA	
6. Personal and biographical data are included in the record.	<ul style="list-style-type: none"> • Includes information necessary to identify patient and insurer and to submit claims. • 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. • Name of the PCP for the patient is indicated in the record (in a group practice, the designated PCP may be documented in the office records).
7. Current and past medical history and age-appropriate physical exam are documented and included serious accidents, operations, and illnesses.	<ul style="list-style-type: none"> • 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 exam. • In pediatric practices, well child visits satisfy this standard. • 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. • History and physical documentation contains pertinent information such as age, height and weight and Body Mass Index, 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. • Pediatric records should also include gestational and birth history documentation.

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	<ul style="list-style-type: none"> Self-administered patient questionnaires are acceptable to obtain base line 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, patients inability or unwillingness to provide information).
8. Allergies and adverse reactions are prominently listed or noted as “none” or “NKA”.	<ul style="list-style-type: none"> 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 the front cover of the chart, on a cover sheet inside the chart, at the top of every visit page, or on a medication record in the chart.) When applicable and known, there is documentation of the date the allergy was first discovered.
9. Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack there of) is recorded when pertinent to proposed care and/or risk screening.	<ul style="list-style-type: none"> Primary care physician must have documentation in the record regarding smoking habits, and history of alcohol use and substance abuse for patients 12 years of age and older, who have been seen three or more times.
10. An updated problem list is maintained.	<ul style="list-style-type: none"> A problem list which summarizes important patient medical information, such as a patient’s major diagnoses, risk factors that affect frequency and indications for preventive care, major diagnostic studies, past medical history, and recurrent complaints, is documented. Continuity of care between multiple practitioners in the same practice is demonstrated by documentation and review of pertinent medical information.
11. There is documentation of discussions of a living will or advance directives for patients 65 years of age or older.	<ul style="list-style-type: none"> A note regarding discussing of living will/advance directives should be present in the medical record.
• VISIT DATA	
12. Patient’s chief complaint or purpose for visit is clearly documented.	<ul style="list-style-type: none"> 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. Telephone encounters relevant to medical issues are documented in the medical record and reflect practitioner review.
13. Clinical assessment and/or physical findings are recorded. Appropriate working diagnoses or medical impressions are recorded.	<ul style="list-style-type: none"> 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. Working diagnoses or medical impressions that logically follow from the clinical assessment and physical examination are recorded.
14. Plans of action/treatment are consistent with diagnosis.	<ul style="list-style-type: none"> Proposed treatment plans, therapies or other regimens are documented and logically follow previously documented diagnoses and medical impressions. Rationale for treatment decisions appear medically appropriate and substantiated by documentation in the record. Laboratory tests are performed at appropriate intervals.

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15. There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.	<ul style="list-style-type: none"> The medical record shows clear justification for diagnostic and therapeutic procedures.
16. Unresolved problems from previous visits are addressed in subsequent visits.	<ul style="list-style-type: none"> Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes.
17. Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.	<ul style="list-style-type: none"> Return to Office in a specific amount of time is recorded at the time of visit, or as follow-up to consultation, laboratory or other diagnostic reports. Patient involvement in the coordination of care is demonstrated through patient education, follow up and return visits.
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.	<ul style="list-style-type: none"> Information regarding current medications is readily apparent from review of the record. 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. When the patient is being seen by multiple practitioners, such as specialists or behavioral health practitioners, there is documentation of consideration of medication interaction.
• EDUCATION	
19. Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated as appropriate.	<ul style="list-style-type: none"> Education may correspond directly to the reason for the visit, to specific diagnosis related issues, such as dietary instruction to reduce cholesterol, or be related to general health maintenance/self-care/preventive health care, such as teaching monthly self-breast examination, or other age appropriate preventive recommendations. Examples of patient noncompliance are documented.
• SCREENING	
20. Screening and preventive care practices are in accordance with the KMHP/AMHP Preventive Health Guidelines.	<ul style="list-style-type: none"> 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. GYN.
21. An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).	<ul style="list-style-type: none"> The patient record includes documentation of immunizations administered from birth to present for members 21 years and under. 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 appropriate age or date the immunizations were given.
• Consultation/Specialty Referral	
22. Requests for consultations are consistent with clinical assessment/physical findings.	<ul style="list-style-type: none"> The clinical assessment supports the decision for a referral. Referrals are provided in a timely manner according to the severity of the patient's condition.
• ANCILLARY, DIAGNOSTIC and THERAPEUTIC SERVICES	
23. Laboratory and other studies are ordered, as appropriate.	<ul style="list-style-type: none"> The clinical assessment supports the decision to order labs and other studies.

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	<ul style="list-style-type: none"> Laboratory tests are ordered at appropriate time intervals.
<p>24. Laboratory and diagnostic reports reflect practitioner review.</p>	<ul style="list-style-type: none"> Results of all lab and other diagnostics are documented in the medical record. 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.
<p>25. Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented.</p>	<ul style="list-style-type: none"> Patients are notified of abnormal laboratory and diagnostic results and advised of recommendations regarding follow-up 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 that the patient is advised of any abnormal results.
<p align="center">• CONTINUITY of CARE</p>	
<p>26. 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"> Consultation reports reflect practitioner review. Primary Care Physician records include consultation reports/summaries (within 60-90 days) that correspond to specialist referrals, or documentation that physician attempted to obtain reports that were not received. Subsequent visit notes reflect results of the consultation as may be pertinent to ongoing patient care. Specialist records include a consultation report/summary addressed to the referral source. 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.