OptimaHealth

Medical Record Documentation Standards

- A current active problem list must be maintained for each member. It should be legible and updated as appropriate. Significant illnesses and chronic medical conditions must be documented on the problem list. If there are no significant problems identified, there must be some notation in the progress notes stating that this is a well child/adult.

- Allergies and adverse reactions must be prominently displayed. If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record. A sticker or stamp noting allergies/NKA on the cover of the medical record is acceptable.

- Past medical history (for patients seen three or more times) must be easily identified and includes family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illnesses.

- Prescribed medications, including dosages and dates of initial or refill prescriptions, are recorded.

- Each page of the medical record contains patient name or identification (ID) number. All entries are dated.

- Working diagnoses and treatment plans are consistent with medical findings. Appropriate plans of action/treatment are consistent with diagnosis(es).

- All requested consults must have return reports from the requesting consultant or documentation of a follow-up phone call must be noted by the primary care physician (PCP) in the progress note. Any further follow-up needed or altered treatment plans should be noted in progress notes. Consults filed in the chart must be initialed by the PCP to signify review. Consults submitted electronically need to show representation of PCP review.

- Continuity and coordination of care between PCP and specialty physicians/provider sites (hospitals, home health, skilled nursing facilities, and free-standing surgical centers) must be evidenced when applicable.

- There should be documentation present in the records of all adult patients (emancipated minors included) that advance care planning/advance directives have been discussed. If the patient does have an advance directive it should be noted in the medical record. A copy of the advance directive should be present in the record.

- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a non-public area, and available upon identification by an approved person. All office staff must be following Health Insurance Portability and Accountability Act (HIPAA) privacy practices.

- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 and older. Referrals to a behavioral health specialist should be documented as appropriate.

- Records should indicate preventive screening services are offered in accordance with Optima Health Preventive Health Guidelines. This should be documented in the progress notes for adults 21 and older.