

MEDICAL RECORDS

Section 11

Overview

Each physician will maintain a complete medical record for each Plan member according to professional practice standards, as well as state and federal requirements.

To comply with regulatory and accreditation requirements, the Quality Improvement department may conduct annual medical record audits in physician offices. A patient's record will be reviewed for content and screenings, as applicable. Physicians will be given results at the time of the audit and a Corrective Action Plan will be required if the score is not above an 80 percent.

Results of all reviews will be housed in a provider profile and considered during re-credentialing and re-contracting.

General Requirements and Guidelines

Medical record requirements and guidelines are as follows:

- Safeguard member confidentiality in accordance with the Health Insurance Portability and Accountability Act (HIPAA) state and federal guidelines, the Plan's Quality Improvement and Risk Management Programs and professional practice standards – Including the confidentiality of a minor's consultation, examination and treatment for a sexually-transmissible disease.
- Make the medical records available for quality-care review studies by Plan reviewers, the United States Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Plan member and organizations conducting accreditation audits, without charge.
- Comply with Corrective Action Plan requirements imposed as the result of any such review or audit.
- Provide, without charge and in a timely manner, a copy of a transferring member's medical

record to the new Primary Care Provider (PCP), when a member changes his/her PCP.

Basic Content Requirements

The following information applies to medical records for Medicare Advantage members.

(Ref. 1)

1. A member's medical record should be neat, complete, clear, concise and timely; should include all recommendations and essential findings.
2. All entries in the medical record must be signed. All entries must include the name and profession of the practitioner rendering services, for example: RN, MD, DO, including signature or initials of practitioner.
3. All entries in the medical record must be dated and recorded in a timely manner.
4. Late entries should include date and time of occurrence and date and time of documentation.
5. Records should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed.
6. Only standard abbreviations and symbols should be used.
7. Medical records must be legible to readers and reviewing parties and maintained in an orderly and detailed manner.
8. The following personal and biographical data must be included in the record: name, member ID#, date of birth, sex, emergency contact and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, telephone numbers, insurance information and family history.

9. All records must reflect the primary language spoken by the member and translation/communication needs of the member. Translation/communication needs could reflect the need for an interpreter, sign language or Braille materials, etc.
10. Medication allergies or “no known allergies” and untoward reactions to drugs, are prominently noted in the record.

This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record.

11. Medical records from the previous provider have been obtained and are easily accessible. Old records include past medical history, physical examinations, necessary tests and possible risk factors for the member relevant to treatment and are used to assess the periodicity schedule and maintain continuity of care.
12. A current immunization record is maintained in the chart.
13. A current medication list is available within the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications.
14. A problem list, with past and current diagnoses and procedures to provide continuity of care, is in the chart. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, etc.
15. Screening for substance abuse of tobacco, alcohol and drugs is conducted, with appropriate counseling/referrals if needed, and follow-up is documented.

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16. There is documentation of screening for domestic violence with appropriate counseling/referrals if needed and follow-up is documented.
17. There is evidence the member was asked about Advance Directives and there is documentation of acceptance or refusal. **Note:** The record must contain evidence that the member was provided written information concerning the member's rights regarding Advance Directives and whether or not the member has executed an Advance Directive. The member does not have to have Advance Directives assigned. A signed statement stating that the member has been asked if he/she has assigned Advance Directives and, if not, asked if he/she wants to assign Advance Directives will suffice for the medical record. A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an Advance Directive.
18. Informed consent discussions, where appropriate, are detailed.
19. Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to "usual" care.

Every Visit Documentation Requirements

The following patient information must be documented in the medical record for each visit:

- History and physical examination as related to the visit, chief complaint or purpose of the visit and objective findings of the practitioner, diagnosis or medical impression.
- Plan of treatment, referrals, disposition, diagnostic testing, studies ordered, therapies administered and prescribed regimens.
- Follow-up plans for abnormal testing/consultation

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reports, referrals or missed/cancelled appointments. There is documentation that the abnormal results or consultation reports were reviewed by the provider and the follow-up care to be done is also documented.

- Patient education and instruction, whether verbal, written or via telephone. The member should be provided with verbal and/or written education/instruction as indicated and appropriate. Significant medical advice given via telephone is entered in the member's record and appropriately signed and initialed. (This includes medical advice provided by after-hours telephone patient information or triage telephone services.)
- Dispositions, recommendations and instructions to the member and evidence of whether there was follow-up and the outcome of these services.

Continuity of Care Requirements

The medical record must show the physician's knowledge of the patient's course of care, as evidenced by the following:

- Documentation and reports of consultations and referrals to specialty physicians, if indicated.
- Reports of diagnostic testing – The medical record must show documentation of reports for diagnostic testing that were ordered: lab results, x-ray reports, MRI/CT reports, etc. Reports must be initialed by the physician.
- Documentation and records for emergency room care. There is documentation in the record if a member was seen in the emergency room and the records from the emergency room visit must be in the medical record.
- Documentation of hospitalizations, including discharge summary and discharge planning. There is documentation in the medical record of the plan for hospital discharge and a copy of the hospital discharge summary for members who were hospitalized.

**General
Documentation
Suggestions**

There is evidence that practice of the following documentation guidelines can potentially reduce practice risks:

- 1. Make documentation descriptive.**
Clinical observations and/or patient symptoms should be documented in detail. Use of anatomical forms or drawings should be considered when documenting the presence, size, color, and/or location of a lesion or deformity.
- 2. Document follow-up instructions clearly.**
This includes activity limitations, medications, referrals to specialists, further testing and subsequent appointments. Make sure patients understand instructions given.
- 3. Obtain and document informed refusal.**
Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures.
- 4. Document all telephone calls from the patient and the patient's responses to them.**
The date and time the call was received, by whom and the date and time it was returned need to be detailed. Fully document any advice given or diagnosis made.
- 5. Establish a follow-up/recall system.**
Some benefits of a recall system include: reduction in potential for failure to diagnose based on abnormal lab results, prompt patient returns for recheck of conditions as indicated by the physician and assurance that the patient sought consultation after referral. This system needs to be established.
- 6. Document every attempt to contact the patient.**
Depending on the seriousness of the condition, you may want to send a certified letter with return receipt.

**Specific Practice
Guideline
Documentation
Requirements****Adult Preventive Health Screening**

The Plan will periodically assess for evidence of compliance to adult preventive guidelines through a review of medical records. The Plan will review for evidence of a complete health assessment within 90 days of the member joining the Plan.

Refer to **the Member and Provider Education Materials** section for a copy of the current guidelines.

Clinical Disease Management

Based on established clinical practice guidelines for chronic obstructive pulmonary disease/asthma, diabetes, hypertension and cholesterol management after an acute cardiac event, The Plan will also periodically assess the medical records of members who experience these conditions for practitioner adherence to guidelines.

References

1. AAAHC Standards for Accreditation
2. American Cancer Society Cancer Detection Guidelines
Web site: <http://www.cancer.org>
3. American Diabetes Association, "Standards of Medical Care for Patients with Diabetes Mellitus"
Web site: <http://diabetes.org>
4. Guide to Clinical Preventive Services, 3rd Edition, 2000-2003 Report of the U.S. Preventive Services Task Force
Web site: <http://www.ahrq.gov/clinic/prevnew.htm>
5. HEDIS® Guidelines
Web site: <http://www.ncqa.org>
6. Recommended Adult Immunization Schedule, United States 2002-2003, Department of Health & Human Services, Centers for Disease Control and Prevention.
Web site: <http://www.cdc.gov>

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7. National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)
Web site: <http://www.nhlbi.nih.gov/about/ncep>
8. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003.
Web site:
<http://rover.nhlbi.nih.gov/guidelines/hypertension/index.htm>
9. The National Asthma Education and Prevention Program (NAEPP), National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003
Web site: <http://rover.nhlbi.nih.gov/about/naepp>
10. Centers for Disease Control and Prevention (CDC)
Web site: <http://www.cdc.gov>
11. QISMC Medical Record Review (Centers for Medicare and Medicaid Services)

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