WellCare
Beyond Healthcare. A Better You.

Medical Record Review Guidelines:

Medical Record Standards – Medical records may be on paper or electronic. WellCare Health Plans, Inc., takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and coordination of services and quality review as follows:

- Patient identification information – Each page or electronic file in the record contains the patient's name or patient ID number.
- Personal/biographical data – Personal/biographical data includes: age, sex, address, employer, home and work telephone numbers, and marital status.
- Entry date – All entries are dated.
- Provider identification – All entries are identified as to author.
- Legibility – The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.
- Allergies – Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
- Past medical history (for patients seen 3 or more times) – Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history related to prenatal care and birth.
- Immunizations – for pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up to date. Documentation of flu/pneumonia vaccines for adults.
- Diagnostic information – List of current diagnosis.
- Medication information – List of current medication.
- Identification of current problems – Significant illnesses and medical conditions are identified in the medical record, including conditions that may affect the Member's ability to perform activities of daily living and instrumental activities of daily living.
- Documentation of any functional or cognitive deficits that impact on performing ADL and IADLs.
- Smoking/ETOH/substance abuse – Notation concerning cigarettes and alcohol use and substance abuse is present. (For patients 12 years and older)
- Consultations, referrals and specialist reports – Notes from any consultations are in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- Domestic Screening – Documentation of screening for domestic violence with appropriate counseling/referrals if needed.
- Family planning services for minor **–** Services necessary for the delay or prevention of pregnancy, pregnancy testing and counseling, and follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Emergency care.

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- Hospital discharge summaries – discharge summaries are included as part of the medical record.
- Advance directive – For adults (ages 18 and older), the medical record documents whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for healthcare relating to the provision of healthcare when the individual is incapacitated.
- The history and physical examination to identify appropriate subjective and objective information for the presenting complaints.
- Treatment plan consistent with presenting complaint.
- Diagnostic tests appropriately order for presenting problem.
- Therapies and other prescribed regimens order are appropriate.
- Follow-up – Encounter forms or progress notes must include a notation follow-up care, call or visit specific time to return is noted in weeks, months or PRN.
- Appropriate referrals and results in the charts.
- Notation of any cultural linguistic needs of the member.

Record review process:

WellCare Health Plans, Inc., has a system (record review process) to assess the content of medical and service records for legibility, organization, completion and conformance to its standards for all providers within its network. The organization also ensures appropriate and confidential exchange of member information among providers.

- A provider making a referral transmits necessary information to the provider receiving the referral.
- A provider furnishing a referral service reports appropriate information to the referring provider.
- Providers request information from other treating providers as necessary to provide care.

Confidentiality of patient information:

WellCare Health Plans, Inc., acts to ensure that the confidentiality of specified patient information and records is protected at all times.

- The Provider office has established policies and procedures on confidentiality, including confidentiality of medical records.
- Information from, or copies of, records may be released only to authorized individuals, and the Provider must ensure that unauthorized individuals cannot gain access to patient records. Original medical and service records must be released only in accordance with federal or state laws, court orders, or subpoenas.
- The Provider ensures that patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.

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