PreferredOne®

Department of Origin: Quality Management	Approved by: Chief Medical Officer	Date approved: 1/31/20
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 1/31/20	
Procedure Description: Medical Record Documentation Guidelines	**Replaces Effective Procedure Dated:** 10/8/15	
Reference #: QM/M001	**Page:** 1 of 2	

PRODUCT APPLICATION:

☒ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
☒ PreferredOne (PPO)
☒ PreferredOne Insurance Company (PIC)

BACKGROUND:

PreferredOne requires medical records to be maintained in a manner that is complete, current, detailed and organized, and permit effective and confidential patient care and quality review.

The medical record for each PreferredOne member, whether paper or electronic, should be an organized, consistent record that accurately communicates information required to render timely, comprehensive medical care.

PROCEDURE:

PreferredOne member health records must be maintained according to all of the following:

I. The medical record must include all the following:

A. For paper records, all pages must contain patient identifier (name or ID#)

B. All record entries must:

1. Be dated; and

2. Must be legible

C. All medical record documentation must include:

1. Patient specific demographic data (address, telephone number(s) and date of birth)

2. A completed problem list that indicates significant illnesses and medical conditions for patient seen three or more times in one year

3. A medication list if applicable, or a note of no medications

4. Medication allergies and other allergies with adverse reactions prominently noted in the record, or documentation of no known allergies (NKA) or no history of adverse reaction appropriately noted

5. Past medical history is identified and includes a review of serious accidents, surgical procedures and illnesses if the patient has been seen three or more times (for children and adolescents, 18 years and younger, past medical history relates to prenatal care, birth, operations and childhood illnesses)

6. Current or history of “use” or “non-use” of cigarettes, alcohol and other habitual substances is present when age appropriate

7. Continuity and coordination of care between the primary care practitioner and consultants as evidenced by consultant's written report or notation of verbal follow-up in the record's notes if consultations are ordered for the member (if applicable)

8. An immunization record/history

9. Evidence that treatment plans are consistent with diagnoses and notes indicating the specific time for return/follow-up in weeks, months, or "as needed" if the member requires follow-up care or return visits

II. Using Templated, Cloned, SmartPhrase or Copy Forward notes regarding clinical circumstances must always be updated on date of service to reflect the evidence that treatment plans are consistent with diagnoses. The final level of service for billing purposes must be based upon the medical necessity of the service actually rendered.

III. Medical records must be stored in a manner that allows easy retrieval and in a secure area that is inaccessible to unauthorized individuals.

IV. Clinic has written policies for:

A. Documented standards for an organized medical record keeping system

B. Confidentiality, release of information and advanced directives

C. Chart availability including between practice sites (if applicable)

D. Reviewing test/lab results and communicating results to patient.

V. Compliance with medical record organization and documentation requirement policies will be monitored as follows:

A. Chart audits will occur in on an annual basis for a sample of practitioner clinics who we have no knowledge of them utilizing an electronic medical record system. A maximum of 10 charts per clinic will be reviewed on a select number of documentation standards for completeness.

B. Clinics surveyed that do not meet an overall rate of at least 80 percent on the standards that are reviewed will be notified of their deficiencies and a corrective action plan will be requested from the clinic addressing how they will conform to the above guidelines with follow-up measurement performed the following year.

REFERENCES:

- Minnesota State Statue 4685.1110, Subp. 13
- MP/C009 Coverage Determination Guidelines

DOCUMENT HISTORY:

Created Date: 5/22/06
Reviewed Date:
Revised Date: 10/26/06, 10/11/07, 10/9/08, 7/9/09, 10/11/13, 10/8/15; 1/31/20